PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a	00	COMPI	LETED
		15G245		LDING		05/20	/2013
			B. WIN	_	DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODELIMENT IND	JANA INO TUE			DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000000							
	This visit was fo	or an extended annual	W0	00000			
	recertification as	nd state licensure survey					
	to a full survey ((Client Protections,					
	_	ices and Governing					
	Body). This vis						
	Immediate Jeopa						
	ininiculate scope	ardy.					
	D	5/7 5/0 5/0 5/10 5/10					
		: 5/7, 5/8, 5/9, 5/10, 5/13,					
	5/14, 5/15, 5/16,	, 5/17 and 5/20/13					
	Facility Number	r: 000768					
	Provider Numbe	er: 15G245					
	AIMS Number:	100234520					
	Surveyors:						
	Paula Chika, QI	DD TC					
	, ,						
	Amber Bloss, Q						
		, QIDP (5/13/13 to					
	5/20/13)						
	These deficience	ies also reflect state					
	findings in acco	rdance with 460 IAC 9.					
		mpleted 5/20/13 by Ruth					
	Shackelford, QIDP						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000768

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G245	B. WIN	G		05/20/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
					OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE		HOBA	RT, IN 46342		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000102	483.410	DV AND MANAGEMENT					
		DY AND MANAGEMENT					
The facility must ensure that specific governing body and management							
	requirements are						
	Based on observa	ation, interview and	W0	00102	W 102 Governing body see w	122	06/01/2013
	record review, th	e facility failed to meet			and 104		
	-	Participation: Governing					
		sampled clients (#1 and					
		ing body failed to ensure					
	, ,	s heath care needs were					
		ected. The governing					
	_	sure the facility's nursing					
	services trained s						
		ic diet, and to ensure					
		d medications according					
		s orders. The governing					
		ercise general policy and					
		on over the facility to					
	ensure the facilit	•					
	_	regard to client to client					
	aggression/abuse	e for client #2.					
	Findings include	:					
		g body failed to ensure					
	the facility met the	he Condition of					
	Participation: Cl	lient Protections for 1 of					
	4 sampled clients	s (client #1). The					
	governing body	failed to implement its					
	written policies a	and procedures to prevent					
	neglect of an inst	ulin dependent client.					
	_	ody failed to ensure the					
		d a consistent risk plan to					
	address client #1						
							<u> </u>

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
11112 12111	or conditions	15G245		LDING		05/20/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE			T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG				TAG	DIA TELENCTY		DATE
		failed to develop menus lelines for staff regarding					
	, , ,	0 0					
		cian ordered diet. The					
		failed to ensure staff were					
	client #1's diabet	gns and symptoms of					
	1 21 03	nd hyper-glycemia. The failed to ensure the					
		yely addressed the client's					
		ntments and labs to					
	prevent recurren						
	_	health risks associated					
	_	diabetes. The governing					
		to implement its policy					
	1 *	o prevent neglect of					
		a significant weight loss.					
	Please see W122	•					
	Flease see W122	··					
	2. The governin	g body failed to meet the					
		ticipation: Health Care					
	Services for 2 of	2 sampled clients (#1					
	and #2). The go	verning body failed to					
		y's Health Care Services					
	met the nursing i	needs of the clients it					
	I -	erning body failed to					
		Care Services assessed,					
	monitored and/o	r addressed a client's					
	health care needs	s in regard to diabetes,					
		ure facility staff were					
	trained in regard	to diabetes and					
	following a diab	etic diet. The governing					
	body failed to en	sure its Health Care					
	Services contact	ed client #1's doctor in					
	regard to low and	d/or high blood sugar	\perp				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G245	B. WIN			05/20/	2013
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
ADC 0F	NODTUMEST IND	IANIA INIC. THE			DURTEENTH LN		
	NORTHWEST INDI	·			T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
1710		ity's governing body		1710	<u> </u>		DATE
		needed risk plans were					
		ients #1 and #2. The					
	_	failed to ensure the					
		Care Services ensured					
	1	client #1's diabetes were					
	administered as						
	administered as	orucicu.					
	3 The governin	g body failed to ensure					
	T -	emented its written					
		cedures to prevent neglect					
	1 ^ ^	harm in regard to Client					
		he governing body failed					
	to ensure the fac						
		oped a risk plan for the					
		The governing body					
		the facility developed a					
	diabetic menu fo	• •					
		nt, and to ensure facility					
	_	ately trained in regard to					
		client's diabetic diet. The					
		failed to ensure facility					
	-	ent #1's low and high					
		ings to nursing staff as					
		lient's physician's order					
	I	olan. The governing body					
		the facility's nursing					
		red the client's diabetes on					
		basis. The governing					
	1	gressively address the					
		of appointments and labs					
		rence of potential					
	-	health risks associated					
	_	diabetes. The governing					

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	A. BUI	LDING	NSTRUCTION 00	COMP	E SURVEY LETED D/2013
PROVIDER OR SUPPLIER		B. WIN	4378 FC	DDRESS, CITY, STATE, ZIP COIDURTEENTH LN)E	
NORTHWEST INDI- SUMMARY S' (EACH DEFICIEN REGULATORY OR body failed to impolicy and proce of client #2 in regulation and proces of client abuse in facility investigated to client abuse in facility's owned of the governing by Health Care Servaddressed/develor #1's diabetes. The governing best of the nursing service diabeted of the program body failed to enterported client # sugar readings to by the client's phorogram plan. Telepote of the phorogram plan.	ANA INC, THE TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Applement its written dures to prevent neglect gard to loss of weight. The description of client avolving client #2 at the day program. The day program. The day program is the process of the	B. WIN	STREET A 4378 FC		DE CTION JLD BE	(X5) COMPLETION DATE
risk plan for clie Infection (UTI) a	nt #1's Urinary Tract and/or, failed to monitor risk plan for client #2's					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2013
	PROVIDER OR SUPPLIED		4378 F	ADDRESS, CITY, STATE, ZIP CODE COURTEENTH LN RT, IN 46342	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	The governing by Health Care Ser regard to diabete required to meet Client #1. The governing by medications were	cody failed to ensure its vices trained staff in es and diabetic menu the health needs of cody failed to ensure e administered per the rs for client #1. Please	TAG	DEFICIENCY)	

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	PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/20/2013	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE OURTEENTH LN	•	
ARC OF	NORTHWEST INDI	ANA INC, THE			RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W000104	483.410(a)(1) GOVERNING BO The governing bo policy, budget, and the facility. Based on observer record review for (#1 and #2), the general direction over the #1 and #2's heath and not neglected failed to exercise operating direction ensure the facility trained staff in rediabetic diet, and administered mention physician's order failed to exercise operating direction over the facility investigations in aggression/abuse. Findings include 1. The governing general policy are over the facility in the governing direction over the facility of the governing direction. The governing direction over the facility of the governing direction over the facility of the governing direction.	dy must exercise general ad operating direction over ation, interview and r 2 of 2 sampled clients governing body failed to policy and operating e facility to ensure client a care needs were met d. The governing body general policy and on over the facility to y's nursing services egard to diabetes/a I to ensure staff dications according to the se. The governing body general policy and on over the facility to y conducted regard to client to client #2.	W0	00104	W 104 Governing body see W and W154, W331, W342, W36		06/01/2013

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	LDING	NSTRUCTION 00	(X3) DATE COMPL 05/20/	ETED
	PROVIDER OR SUPPLIER		 4378 FC	DURTEENTH LN T, IN 46342	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	facility specificarisk plan for the governing body policy and opera facility to ensure diabetic menu for follow/implements staff were adequediabetes and the governing body policy and opera facility to ensure client #1's low and readings to nursification the client's physical program plan. To exercise general direction over the facility's nursing client's diabetes. The governing begeneral policy and over the facility aggressively addirections of appoint prevent recurrent hospitalizations/ with the client's body failed to expoperating directions and proceed the facility policy and proceed the sure that the sure th	ately trained in regard to client's diabetic diet. The failed to exercise general ting direction over the the facility staff reported and high blood sugar ng staff as outlined by cian's order and/or the governing body failed ral policy and operating e facility to ensure the services monitored the on a more frequent basis. The odd failed to exercise and operating direction to ensure the facility ressed the client's and labs to				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
11112 12111	or condition,	15G245		LDING		05/20/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	1			OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE			T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEI ICIENCI)		DATE
	Please see W149	'.					
	2 The governin	g body failed to exercise					
	T =	nd operating direction					
	1	to investigate allegations					
	1	t abuse involving client					
		's owned day program.					
	Please see W154						
	3. The governin	g body failed to exercise					
	general policy as	nd operating direction					
	over the facility	to ensure the facility's					
	Health care Serv	rices specifically					
	addressed/develo	oped a risk plan for client					
	#1's diabetes. Tl	he governing body failed					
	to exercise gener	ral policy and operating					
	direction over th	e facility to ensure the					
	facility's Health	Care Services obtained a					
	diabetic menu fo	or facility staff to					
	follow/implemen	nt, and failed to ensure					
	facility staff wer	e adequately trained in					
		es and the client's diabetic					
	diet. The govern	ning body failed to					
	_	policy and operating					
		e facility to ensure the					
	<u>-</u>	Care Services monitored					
		tes on a more frequent					
		d the physician as					
		client's program plan.					
		verning body failed to					
	_	policy and operating					
		e facility to ensure the					
	<u>-</u>	Care Services ensured					
	facility staff repo	orted client #1's low and					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G245	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	4378 F0	ADDRESS, CITY, STATE, ZIP CODE DURTEENTH LN T, IN 46342	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE COMPLETION
	high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services developed a risk plan for client #1's Urinary Tract Infection (UTI) and, failed to monitor and/or develop a risk plan for client #2's weight loss. Please see W331. 4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services trained staff in regard to diabetes and diabetic menu required to meet the health needs of Client #1. Please see W342. 5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services administered medications per the physician's orders for client #1. Please see W368. 9-3-1(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G245	B. WIN			05/20/	2013
NAME OF B	DOMDED OD CHINI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			4378 F	OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE		HOBAF	RT, IN 46342		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W000122	483.420 CLIENT PROTEC	TIONS					
		ensure that specific client					
	protections requir						
	Based on observe	ation, interview, and	W0	00122	Client protectionThe client was	6	06/01/2013
	record review, th	e facility failed to meet			taken to the ER on 5/9/13 and		
	the Condition of	Participation: Client			blood sugar was brought up to		
	Protections for 1	of 4 sampled clients			range then he was released. I was then taken to the doctor o		
	(client #1). The	•			5/14/13 by the Service	••	
	· ·	ritten policies and			Coordinator and Community		
	-	event neglect of an			Services Nurse. A full medical		
	insulin dependent client.				assessment was completed. Labs were ordered and his slid	dina	
	1				scale was discontinued. Advice	-	
	This non-compli	ance resulted in an			was given on modifying his ris	k	
	_	rdy as the facility			plan including but not limited to)	
	•	elop a consistent risk plan			monitoring blood sugar, signs symptoms and response to high	ah.	
	_	#1's diabetes. The			reading, signs symptoms and	Ji i	
		l to develop menus with			response to low readings,		
	· -	s for staff regarding the			notifying the community service	es	
		ordered diet. The			nurse, when to notifying the		
		to train staff on the			physician, accurate use of a sliding scale (discontinued) an	d	
		ns of client #1's diabetes			the use of Glucerna. Nursing	u	
	as related to hype				staff began visiting the group		
	• •	The facility neglected to			home daily beginning on 5/9/1		
		ress the client's refusals			and began signing in at the ho on 5/20/13. Observations hav		
		and labs to prevent			included meal time, medication		
		spitalizations/health risks			administration, and		
		he client's diabetes. The			documentation review of the	_	
		ardy began on 4/19/2013			MAR, blood sugar readings, at his journal. Nurses have begu		
	_	was identified on 5/09/13			training staff on the Suppleme		
		Director of Community			Lesson in Core A of Living in t		
		unity Services Operations			Community, the revised risk pl		
		oral Health Director,			(as noted above) reading bloo	d	
	, , , , , , , , , , , , , , , , , , ,	es Coordinator, Director			sugars, administering insulin injections via flex pen, signs a	nd	
	of Health Care S				symptoms of hyper and		
	or ricarui Care S	or vices, and the	1		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G245	B. WIN			05/20/2013	
NAME OF B	ADOLUDED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			4378 F0	OURTEENTH LN		
	NORTHWEST INDI	ANA INC, THE		HOBAR	RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE	
		tor were notified of the of			hypoglycemia and the use of glucerna specifically on 5/9/13		
		eopardy on 5/10/13 at			This training and future training		
	12:15 PM. The facility submitted a plan				include modeling the appropria		
	for removal of th	ne Immediate Jeopardy on			skills and return demonstration		
	5/15/13 at 6:01 F	PM. The facility's plan of			of the necessary skills. Addition		
	action/removal is	ndicated client #1 would			training will be provided as the		
		octor on 5/14/13 to			client's orders change and who		
		edical assessment			new staff enter the house.In or to prevent reoccurrence all sta		
	-	eded labs and written			will be trained on the risk plan,		
		s to the management of			this training will include		
		•			demonstration of reading bloo	d	
		including but not limited			sugars, administering insulin		
	_	specific sliding scale and			injections via flex pen and use		
	routine insulin				the sliding scale (if applicable)		
	instructions/adm	inistration, when to			The client high risk plan was modified on 5/9/13, and again	on	
	notify the physic	ian, signs, symptoms of			5/14/13, and again on 5/22/13		
	hyper and hypog	lycemia and the use of			Additionally, a journal was		
	the Glucerna spe	ecifically to this client's			developed on 5/9/13, staff was	3	
	needs" The fa	cility's plan indicated			trained on it 5/9/13 and it was		
		lan would be revised to			implemented on 5/10/13– which		
	_	ormation received from			includes blood sugar readings and interventions, intake and	,	
		The facility's plan of			applicable behavioral		
		• •			observations. The community		
		d facility staff would fax			services nurse will review this		
		sugar levels to the nurse			journal daily during their home		
	1	plan indicated a journal			visit. The Director of Health		
	_	nented by 5/11/13 "to			Services will monitor that the		
	include blood su	gar readings, and			nursing staff is reviewing this		
	interventions, int	take and applicable			information through weekly meetings for three months and	,	
	behavioral obser	vations. The community			then monthly thereafter. A sea		
	services nurse w	ill review this journal			for glucometers that allow for		
		nding outside of the risk			uploading of reading will be		
		will result in additional			investigated so readings can b		
	_	until such time that the			reviewed in real time. In addit	· · · · · · · · · · · · · · · · · · ·	
	_				the use of electronic MARS wi		
		tely implemented. The			be investigated with upcoming new software.Until such time t		
	service coordina	tor will monitor that the			now software. Onthi such time t	iid.	

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MU A. BUII B. WIN	LDING	onstruction 00	(X3) DATE S COMPLI 05/20/2	ETED
	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE DURTEENTH LN PT, IN 46342	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	in a timely mannof the information then monthly the plan indicated a form would be so discharge of clie the facility's nursinformation with "or when lab recompleted" The nurse did not obtain facility's plan of staff would be traplan on 5/21/13. The area manager we training prior to the area manager we training will increading blood surand use of the slam that the nutritionist we calorie diabetic in the nutritionist we calorie diabetic in the staff on 5/21/13.	deceiving this information are through weekly audits on for three months and breafter" The 5/15/13 release of information ent to the hospital upon onts. The plan indicated se would obtain this ain 48 hours of discharge esults have been the plan indicated if the fain the information, the fain the information. The removal indicated facility fained on the revised risk. The plan indicated "If fassigned to the home the fill refer the staff for working at the home. Follude demonstration of gars, drawing injections fiding scale (if applicable). For will audit the training ff that work at this home sis for three months, she for three months, she for three months, she aff's training records for employment thereafter. Indicated the nutritionist service and group home of the plan also indicated for would develop an 1800 menu. The risk plan ritionist would visit the			the staff has shown competent in the skills, the nurse will continue to do observations at home daily. Once competent has been demonstrated, the frequency of visits will decreast to every other day for two west then weekly for one month an monthly thereafter. Nursing statrained staff on existing diabed diets on 5/9/13 (these plans who that the home at the time of survey). As orders have chan and risk plans revised. Additionally, and develop sample 1800 calculationally diabetic menus as guidelines menu development by 5/22/13. The client's diabetic diet plans be revised. In order to prever reoccurrence the dietician will train both home and day progron the risk plan, this training winclude a demonstration on making exchanges and identification appropriate day time snacks. Following this training the dietician will visit the home with 2 weeks and will observe a meand document her observation Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in a home on 5/20/13. Observation have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, a his journal. Nurses have begut training staff on the Supplementations on the Supplementation of the Supp	the y seks d afficere edonal set the good set to read so the good set to read	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED
		15G245	A. BUII B. WIN	LDING G		05/20/2013
		1	b. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEI	₹			OURTEENTH LN	
ARC OF	NORTHWEST IND	IANA INC, THE			RT, IN 46342	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		veeks and observe a meal.			Community, the revised risk p	I
	The risk plan in	dicated a behavior plan			(as noted above) reading bloc sugars, administering insulin	ou
	would be develo	pped to address the client's			injections via flex pen, signs a	and
	refusals of labs	and medical assessments			symptoms of hyper and	
	by 5/28/13.				hypoglycemia and the use of	
					glucerna specifically on 5/9/13	I
	Based on observ	vation, interview and			This training and future training	
		f the facility's 5/15/13			include modeling the appropri skills and return demonstratio	
		l, it was determined the			of the necessary skills. Additi	
		action had not removed			training will be provided as the	
	the Immediate J				client's orders change and wh	nen
					new staff enter the	
	_	ardy continued because			house.Additionally, a journal v	
		ed to still train staff in			developed on 5/9/13, staff we trained on it 5/9/13 and it was	
	1	#1's diabetic diet as the			implemented on 5/10/13 – wh	
		not be at the facility until			includes blood sugar readings	
		staff. The facility still			and interventions, intake and	
	needed to obtain	an 1800 calorie diabetic			applicable behavioral	
	diet menu, inclu	ding a list of snacks for			observations. The Communit Services Nurse will review this	-
	client #1. The fa	acility also needed to			journal daily during their home	
	update client #1	's risk plan to match the			visit. The Director of Health	
	client's changes	in insulin order, and to			Services will monitor that the	
	_	ty's nursing services			nursing staff is reviewing this	
		s's blood glucose levels on			information through weekly	-1
		basis, as the plan did not			meetings for three months and then monthly thereafter. Final	
	_	en the facility's nurse			Client #1 continues to see his	• •
		group home to monitor			doctor and specialist. His risk	
		facility still needed to			plan will be modified following	
		which addressed client			each visit as necessary and w	
					be distributed to the home and	a
		regard to medical			day program with additional training as needed.Please see	e W
		sts. The facility's plan of			149 and W 154 for additional	
		specifically indicate how			planning	
	1	d ensure staff would be				
		ed prior to working in the				
	home. The facil	ity still needed to				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 05/20	ETED
	PROVIDER OR SUPPLIER		b. WINC	STREET A	DURTEENTH LN T, IN 46342	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Ε	(X5) COMPLETION DATE
	correction/remov	nonitor its plan of val, over a period of time, ctiveness to meet the s of the client.					
	between 5:10 PM group home, clie consisted of 1 br tots, approximate vegetables (corn carrots), milk and diet menu was pethe group home. and #7 on 5/13/1 no 1800 calories						
	between 10:30 A day service prog calorie diet ment program. Client appointment con diabetes. Client a on 5/14/13 at 10 2013 Medication (MAR) indicated level on 5/14/13 the Health & (an 5/14/13 at 10:45	13 observation period M and 11:45 AM, at the ram, there was no 1800 at the day service #1 was at a doctor's cerning the client's #1's record was reviewed #30 AM. Client #1's May Administration Record I client #1's blood sugar was 319. Interview with d) Safety Tech (HST) on AM indicated the facility eation book which the					

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	OF CORRECTION OF CORRECTION 15G245	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	4378 F0	ADDRESS, CITY, STATE, ZIP CODE DURTEENTH LN RT, IN 46342	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	group home and day service staff were to document in on what client #1 ate at the day service program. The HST indicated the day service staff had not been trained in regard to the client's diet, diabetes and carbohydrate exchange. Interview with the food service staff #2 on 5/14/13 at 10:58 AM stated "There was no special diet for [client #1]. He is given the same diet as all the other clients." Food service staff #2 stated the day service staff was told to give client #1 extra water "since he is always thirsty." The Day Program Director was interviewed on 5/14/13 at 11:40 AM. The Day Program Director indicated day program staff had not been trained in regard to the menus submitted for the day program. The Day Program Director stated client #1 was given "The [name of company] juice with sugar and drinks throughout the day because "He is always thirsty." During observations on 5/15/13 between 3:50 PM and 4:30 PM, at the day program, the day program did not have an 1800 calorie diet menu. Client #1's diet sheet indicated client #1 consumed a "pretzel with cheese, potato chips, 1 cup of water, 1 can of Glucerna, 1 cookie, 1 pudding and diluted apple juice." Interview HST #2 on 5/15/13 at 4:10 PM indicated client #1's doctor had discontinued the sliding scales and testing			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15G245	B. WIN			05/20/2	013
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL IMPORTANT	IANIA INIO TUE			DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TΕ	COMPLETION DATE
TAG		,		TAG	BHICKET		DATE
		sugar level before lunch.					
		to come back and forth					
	_	service program and the					
	group nome, was	s not sent in on $5/15/13$.					
	Dunin a 41 5/15/	12 observation					
	~	13 observation period 1 and 5:30 PM at the					
		re was no 1800 calorie					
		d/present in the group follow. Interview with					
		on 5/15/13 at 4:50 PM					
		nus had not been					
		o training had occurred.					
		ndicated they were told					
		sting client #1's blood					
	_	efore meals and to					
		client's sliding scale					
	1 -	#6 and #7 indicated					
		d 15 units of insulin in					
	the morning and	at bed time.					
	G1:						
		d was reviewed on					
		AM. Client #1's 5/14/13					
		nge Form indicated					
		nue with Novolog mix					
		sic) Test blood sugar					
		Give 15 units of Insulin					
	`	us) before he eats. Hold					
		sugar is under 70 and call					
		d sugar before dinner.					
		Insulin sub Q before he					
		in if blood sugar is under					
	70 and call nurse	e. Call nurse if B/S (blood					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JLTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL	
		15G245	B. WIN			05/20/	2013
NAME OF E	PROVIDER OR SUPPLIE	2	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					DURTEENTH LN		
ARC OF	NORTHWEST IND			HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		nan 300." The 5/14/13		1710	<u> </u>		DATE
		client #1's sliding scale					
		d sugar checks at lunch					
	and bedtime we	_					
	Client #1's 1800	ADA Calorie Diet					
	exchange sheet	indicated facility staff					
	were documenti	ng what client #1 ate.					
	Client #1's 5/15/	13 exchange sheet					
	indicated the day	y service staff					
	documented "*N	No Binder sent in today					
	with consumer.'	•					
	Client #1's 5/9/1	3 Diabetic Plan indicated					
	staff would be to	rained on an 1800 calorie					
	_	lan indicated staff were to					
	_	t #1 to choose "healthy					
		The plan indicated staff					
		d on blood sugar					
	_ ·	client #1's blood sugar					
		taken 4 times a day. The					
	•	Celient #1's blood sugar					
		aff were to check the					
		oms of Hypoglycemia as					
	indicated by the	following:					
	"-Hunger						
	-Sweating -Confusion						
	-Confusion -Shakiness						
	-Dizziness						
	-Anxiety						
	-Nervousness						
	-Sleepiness						
	-Weakness						

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		NSTRUCTION 00	(X3) DATE COMPI	
	15G245	A. BUILDING B. WING		05/20	
			DDRESS, CITY, STATE, ZIP CODE	_	
NAME OF	PROVIDER OR SUPPLIER		OURTEENTH LN		
ARC OF	NORTHWEST INDIANA INC, THE		T, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	-[Client #1] may also pull himself into a				
	fetal position/curled into a ball." The plan				
	indicated staff were to monitor for these				
	symptoms throughout the day, and to test				
	the client's blood sugar when symptoms				
	present. The 5/9/13 risk plan indicated if				
	the client's sugar was low the staff were to				
	offer the client orange juice, pop, cookies,				
	milk, "Glucose Gel/Gel Icing" and/or				
	cake frosting. The risk plan also				
	indicated if client #1's blood sugar level				
	was above 200 staff should monitor/check				
	the client for				
	"-Frequent urination				
	-Fatigue				
	-Abdominal Pain				
	-Dry Mouth				
	-Increased thirst				
	-Headache				
	-Nausea and Vomiting				
	-Weakness				
	-blurred vision				
	-Fruity Smelling breath				
	-Shortness of Breath				
	-Confusion				
	-Coma				
	-[Client #1] may also pull himself into a				
	fetal position into a ball." The risk plan				
	indicated "If [client #1's] blood sugar is				
	above 300 encourage him to drink water,				
	call the nurse. Retest in one hour. If it is				
	still above 300 call 911. If [client #1] is				
	sick and not able to keep fluids down And				
	his blood sugar is above 300 mg/dl Call				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G245	B. WIN			05/20/	2013
NAME OF F	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST IND	IANIA INC. THE			DURTEENTH LN T, IN 46342		
		·		<u> </u>	.1, 111 40342		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1110		nurse. If [client #1's]		1110			BIIIE
		00 encourage him to					
	1 ~	Call 911 and then the					
		9/13 risk plan indicated					
		be sent from home to					
	-	and returned each day.					
	1 31 0	ment his blood sugar					
		of units, and what he					
	_	Monday a this (sic)					
		ent to the community					
	1 "	A new journal is to be					
		e Immediate Jeopardy					
	was not removed						
	was not removed	1.					
	Dagad on observ	ation, interview and					
		r 1 of 2 sampled clients,					
		•					
		neglected to implement					
		and procedures to					
	_	of the client in regard to					
	weight loss.						
	Findings in alada						
	Findings include	·					
	1 The facility n	eglected to implement its					
	1	and procedures to prevent					
	_	otential harm in regard to					
	Client #1's diabe	•					
		cifically address/develop					
		e client's diabetes. The					
	_	d to develop a diabetic					
		•					
	menu for facility						
	_	nt, neglected to ensure					
	_	e adequately trained in					
	regard to diabete	es and the client's diabetic					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MULT A. BUILDII B. WING		OO	(X3) DATE S COMPL 05/20/	ETED
	PROVIDER OR SUPPLIER		4	378 FO	DDRESS, CITY, STATE, ZIP CODE URTEENTH LN , IN 46342	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility staff reporting high blood sugar as outlined by the order and/or progregated to ensure services monitor a more frequent neglected to agging client's refusals of to prevent recurring hospitalizations/with the client's also neglected to policy and processor of client #2 in replease see W149	health risks associated diabetes. The facility implement its written dures to prevent neglect gard to loss of weight. hiled to investigate ent to client abuse #2 at the facility's owned					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G245	B. WIN			05/20/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			OURTEENTH LN RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
W000149	The facility must of written policies are mistreatment, negotial series and on observinterview for 1 of the facility negles written policies and neglect and/or possible the client's diabeted to spectarisk plan for the facility neglected menu for facility follow/implement facility staff were regard to diabeted diet. The facility facility staff reposition blood sugar as outlined by the order and/or progneglected to ensure services monitor a more frequent in neglected to aggin client's refusals of the prevent recurring with the client's of the services with the client's of the services with the client's of the services and the services with the client's of the services and the services with the client's of the services and the services with the client's of the services and the services with the client's of the services and the services are services are services and the services are services ar	cifically address/develop e client's diabetes. The d to develop a diabetic staff to nt, neglected to ensure e adequately trained in s and the client's diabetic r neglected to ensure orted client #1's low and r readings to nursing staff e client's physician's gram plan. The facility are the facility's nursing ed the client's diabetes on basis. The facility ressively address the of appointments and labs ence of potential health risks associated	W0	00149	treatment of the client was tak to the ER on 5/9/13 and his blus ugar was brought up to range then he was released. He was then taken to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his slice scale was discontinued. Advice was given on modifying his risical plan including but not limited to monitoring blood sugar, signs symptoms and response to his reading, signs symptoms and response to low readings, notifying the community service nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/1 and began signing in at the hoon 5/20/13. Observations hav included meal time, medication administration, and documentation review of the MAR, blood sugar readings, at his journal. Nurses have begut training staff on the Suppleme Lesson in Core A of Living in the Community, the revised risk please in the supplementation of the supplementati	l ding ce k co gh es d 3 me en ntal he ans d	06/01/2013
	record review for	r 1 of 2 sampled clients,			via flex pen, signs and sympto		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DINC	00	COMPLE	ETED
		15G245	A. BUII B. WIN			05/20/2	2013
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE			RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(#2), the facility	neglected to implement			of hyper and hypoglycemia an		
	its written policy	and procedures to			the use of glucerna specifically		
	prevent neglect	of the client in regard to			5/9/13. This training and futur trainings include modeling the		
	weight loss.				appropriate skills and return		
					demonstrations of the necessar	ary	
	Findings include	·			skills. Additional training will b	pe	
	i mamga meraak	•			provided as the client's orders		
	1 During the 5	/8/13 observation period			change and when new staff er	nter	
		*			the house.In order to prevent reoccurrence all staff will be		
		M and 8:00 AM, at the			trained on the risk plan, this		
		ff #2 assisted client #1 to			training will include demonstra	ntion	
		er for the day at 6:05 AM.			of reading blood sugars,		
		ff #2 went to the kitchen			administering injections via fle		
	and retrieved a s	lice of whole wheat bread			pen and use of the sliding sca		
	and took the bre	ad to client #1 in his			(if applicable). The client high risk plan was modified on 5/9/		
	bedroom. At 6::	52 AM, staff #3 prompted			and again on 5/14/13, and again		
	client #1 to com	e and get his morning			on 5/22/13. Additionally, a jou		
	medications. Pr	ior to client #1 receiving			was developed on 5/9/13, staf	f	
	his morning med	dications, staff #3 did a			were trained on it 5/9/13 and i		
	blood sugar test	which was 194 (test done			was implemented on 5/10/13 -	_	
	after client #1 re	eceived the slice of bread).			which includes blood sugar readings, and interventions,		
		ed oral medications only			intake and applicable behavio	ral	
		7:25 AM, staff #3			observations. The Community		
		ed client #1 to leave the			Services Nurse will review this		
		le to come back to the			journal daily during their home	•	
		n. Client #1 refused to			visit. The Director of Health Services will monitor that the		
		room table and was			nursing staff is reviewing this		
	_				information through weekly		
		t food to eat. Staff #3			meetings for three months and		
	_	and the client's toast to			then monthly thereafter. A sea	rch	
	_	#1 to follow her back to			for glucometers that allow for uploading of reading will be		
		Client #1 left the dining			investigated so readings can be	_{oe}	
		followed staff #3 to the			reviewed in real time. In addit		
		7:43 AM, staff #3			the use of electronic MARS wi	ill	
		ovolog 70/30 15 units of			be investigated with upcoming		
	insulin (Diabete	s) via an insulin injection			new software.Until such time t	nat	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI		JLTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G245	B. WIN			05/20/2013	
				_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE			RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG		5.112	
	_	Client #1 then returned			the staff have shown compete in the skills, the nurse will	ncy	
	to the dining room table to eat his				continue to do observations at	the	
		45 AM, client #1 was			home daily. Once competenc		
	served one slice	of whole wheat toast, a			has been demonstrated, the		
	bowl of grits, 1	small cup of apple juice, a			frequency of visits will decrease		
	cup of milk and	a can of Glucerna (help			to every other day for two wee then weekly for one month and		
	minimize blood	sugar spikes) shake to			monthly thereafter. Nursing sta		
	consume. Once	client #1 ate the bowl of			trained staff on existing diabet		
	grits, staff #2, w	ho was at the table			diets on 5/9/13 (these plans w	ere	
	standing near cli	ient #1, asked client #1 if			not at the home at the time of		
	I -	grits. Staff #2 placed a			survey). As orders have chan		
		of grits into client #1's			and risk plans revised. Addition trainings will be provided. The		
		AM, staff #2 asked client			dietician to make a home visit		
		more grits. Staff #2 then			and develop sample 1800 cald		
		rving of grits into client			diabetic menus as guidelines		
	_	nt #1 ate the bowl of grits			menu development by 5/22/13		
		nis Glucerna shake. At			The client's diabetic diet plan be revised. In order to preven		
					reoccurrence the dietician will		
		group home's kitchen, a			train both home and day progi	ram	
		a regular diet was posted			on the risk plan, this training w	/ill	
	_	gerator. The group home			include a demonstration on		
		1800 calorie diabetic diet			making exchanges and identif	ying	
	_	he 5/8/13 menu indicated			appropriate day time snacks. Following this training the		
		eceive apple juice, 1 bowl			dietician will visit the home wit	hin	
	of grits and a sli	ce of toast.			2 weeks and will observe a me	eal	
					and document her observation		
		taff #2 on 5/8/13 at 6:30			Nursing staff began visiting the group home daily beginning or		
	AM indicated sh	ne was getting the slice of			5/9/13 and began signing in a		
	bread for client	#1. When asked why,			home on 5/20/13. Observation		
	staff #2 stated sh	ne was getting the slice of			have included meal time,		
	bread "So [clien	t #1's] blood sugar will			medication administration, and	d	
	not be low." Sta	aff #2 indicated client #1's			documentation review of the	nd	
	blood sugar wou	ald be high and then low.			MAR, blood sugar readings, a his journal. Nurses have begu		
					training staff on the Suppleme		
	Interview with s	taff #2 on 5/8/13 at 8:04			Lesson in Core A of Living in t		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	A. BUILDING 00		COMPLETED	
		15G245		B. WING 05/20/2013			013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OURTEENTH LN		
ADC OF	NODTUMEST IND	ANA INC. THE			RT, IN 46342		
ARC OF	NORTHWEST IND	ANA INC, THE		HUBAN	(1, IN 40342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	AM stated client	#1 was on a "diabetic			Community, the revised risk pl		
	diet." When ask	ed where the diet was			(as noted above) reading blood	d	
	nosted staff#2 (could not locate the			sugars, administering insulin		
	_	aff #2 then went to the			injections via flex pen, signs a	nd	
					symptoms of hyper and hypoglycemia and the use of		
		stated client #1 was on			glucerna specifically on 5/9/13		
		diabetic diet." Staff #2			This training and future training		
	had an April 201	3 Menu which had an			include modeling the appropria		
	1800 calorie Dia	betic diet written in red			skills and return demonstration		
	ink at the top of	the menu. Staff #2			of the necessary skills. Addition		
	indicated client #1 could have what was				training will be provided as the		
					client's orders change and who	en	
	written on the regular menu unless something was written in red by the menu				new staff enter the		
	_	_			house.Additionally, a journal w		
		y's posted May 2013			developed on 5/9/13, staff wer	e	
	regular menu dic	I not have any red			trained on it 5/9/13 and it was implemented on 5/10/13 – whi	ch	
	notations on the	5/13 menus for the			includes blood sugar readings		
	month of May.	When asked what menu			and interventions, intake and	'	
	staff #2 followed	I for client #1 at the			applicable behavioral		
		staff #2 indicated she			observations. The community		
		ted menu in the kitchen.			services nurse will review this		
	l lollowed the pos	ted mend in the kitchen.			journal daily during their home		
					visit. The Director of Health		
		taff #3 on 5/8/13 at 8:15			Services will monitor that the		
	AM indicated cla	ient #1 was diabetic and			nursing staff is reviewing this		
	was on an 1800	calorie diabetic diet.			information through weekly meetings for three months and	.	
	Staff #2 indicate	d the posted menu in the			then monthly thereafter. Finally		
		regular diet. When			Client #1 continues to see his	,,	
		t #1 was to receive since			doctor and specialist. His risk		
					plan will be modified following		
		00 calorie diabetic diet,			each visit as necessary and wi	ill	
		We just know what he			be distributed to the home and		
		taff #3 indicated staff did			day program with additional	_	
	not assist client	‡1 to measure his			training as needed.A risk plan	tor	
	food/servings. Staff #3 stated "He does				client #2 was developed on		
		sure it out. We do by			5/28/13 to include weekly weig and guidelines for reporting	JIIIS	
		stated the group home			changes. All staff will be trained	_{-d}	
	_				on this plan by 6/5/13. Client v		
	was using "an ex	change." Staff #3 stated			on this plan by 0/5/15. Offent (·*·	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15G245	B. WIN			05/20/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L		4378 F0	OURTEENTH LN	
	NORTHWEST IND	IANA INC, THE		HOBAR	RT, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE
		ead equals 1 cup." Staff			be evaluated by his primary physician and dietician by	
	#3 indicated client #1 should not have				6/15/13. Any recommendation	ns
		s of grits at the breakfast			will be added to his risk plan.	
		ed if staff #3 had been			Nursing staff began visiting the	
		to signs and symptoms			group home daily beginning or	
		gh blood sugar, staff #3			5/9/13 and began signing in at home on 5/20/13. Observation	
		"some signs." Staff #3			have included meal time,	
	indicated client #	#1 had not demonstrated			medication administration, and	ı
	any signs of low and/or high blood sugars when she worked. Staff #3 did not				documentation review of the	
					MAR. This training and future	
	specifically indic	cate she had been trained			trainings include modeling the appropriate skills and return	
	and/or indicate v	when she was trained.			demonstrations of the necessar	ary
					skills. Additional training will b	- I
	During the 5/8/1	3 observation between			provided as the client's orders	•
	_	2:28 PM at day service			change and when new staff er	iter
		11 AM, Client #1 was			the house. Daily visits will continue until staff has	
		at a table for lunch.			demonstrated competency and nurse monitoring will phase out	d l
	1	usage pizza broken up				t
		d with Italian dressing and			according to competency	
	_	Staff #6 indicated Client			demonstrated then monthly thereafter.	
	•	aten his french fries			mercaner.	
	1	M. Client #1 was				
		rn to his day service				
		AM, Staff #7 was				
		Client #1's lunch plate				
		vave and offer it to him.				
		d to eat anymore of his				
		kept his cup of water				
		ntinued to drink the				
		AM, Client #1 was				
		l his glass of water at the				
	•	tly and then sit on the				
		AM, Client #1 was				
	checking door ki	nobs to straighten them				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245 A. BUILDING B. WING O5/20/2013 STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN LODADT, IN 16242	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN	(Y5)
NAME OF PROVIDER OR SUPPLIER 4378 FOURTEENTH LN	(Y5)
ADO OF MODITIMEST INDIANA INC. THE	(Y5)
ARC OF NORTHWEST INDIANA INC, THE HOBART, IN 46342	(Y5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION DATE
and picking lint off carpet and eating it.	DATE
At 11:56 AM, Client #1 was observed	
sitting on the couch holding his cup of	
water and drinking his water throughout	
the observation. At 12:02 PM, the client's	
diet roster was observed taped to a	
cabinet. The diet roster indicated Client	
#1 was on a "NCS" (No Concentrated	
Sweets) diet. At 12:24 PM, Client #1 was	
offered another lunch plate which he	
refused to eat.	
On 5/7/13 at 11:53 AM, the Bureau of	
Developmental Disabilities Services	
(BDDS) reports and internal incident	
reports were reviewed and indicated the	
following:	
-A BDDS report dated 2/13/13 indicated	
on 2/9/13 staff reported Client #1's	
disposition had changed and his blood	
sugar was checked. Staff reported Client	
#1 did not want to eat and did not seem as	
active as usual. The report indicated	
Client #1's blood sugar was above the recommended level and the nurse	
instructed staff to take Client #1 to the	
hospital "immediately." The report	
indicated Client #1 was admitted to the	
hospital for high blood sugar and "a	
stomach infection which may have caused	
his sugar to raise." The report indicated	
Client #1 was discharged from the	
hospital on 2/13/13.	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G245	A. BUII B. WIN	LDING		05/20/	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF			
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OR	LSC IDENTIFTING INFORMATION)		TAG			DATE
	An internal incid	lent report dated 2/9/13					
		#1 had been reported sick					
		on 2/8/13. The report					
	indicated Client	_					
	extremely abnor	mal, he was not eating or					
	drinking." The r	report indicated Client #1					
		hospital. On 5/9/13 at					
		rse emergency call log					
dated 2/9/13 indicated Client #1's blood							
sugar was in the 300's with irregular vitals							
	-	mitted to the emergency					
	room.						
	An incident ren	ort summary sheet dated					
	-	d Client #1 was drinking					
		ody motion became					
		report indicated Client #1					
		and was about to fall out					
		port indicated staff called					
	911 and then the	nurse. The report					
	indicated Client	#1 refused to go with the					
	_	e hospital and they					
		t #1 to eat before they					
		at 2:39 PM, review of the					
		call log dated 3/14/13					
		#1's blood sugar was 52					
	before the param	nedics had arrived.					
	A DDDC ranget	dated 4/19/13 indicated					
		I sugar dropped to 30 at					
		eport indicated staff					
		e Client #1 soda but he					
	1 0	curled up, and would not					
		* *					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G245	B. WIN	G		05/20/2013
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					DURTEENTH LN	
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)	DATE
		e report indicated Client				
	#1 was transported to the hospital. On					
		M, review of the nurse				
		og indicated Client #1				
	_	from hospital after a				
	_	1 of 32 and a diagnosis of				
	urinary tract infe	ection.				
	-A BDDS report dated 4/25/13 indicated on 4/24/13 at 7:30 PM, Client #1 was out in the community shopping when he					
		' and staff supported him				
		The report indicated an				
	_	driving by and was asked				
		ramedics checked Client				
	_					
	_	which read 174. The				
		staff began to take Client				
		an when he began				
		port indicated the				
	_	e located and took Client				
	_	l where he was checked				
	and released the	same day.				
	During interview	on 5/9/13 at 5:35 PM,				
		pecialist indicated Client				
		bulance on his way to the				
		ow blood sugar levels.				
	nospital due to le	0100a bagai 1010ib.				
	On 5/9/13 at 2:1	9 PM, a record review for				
	Client #1 indicat	ed client #1's diagnoses				
	included, but we	re not limited to,				
	Diabetes Mellitus, Mental Retardation,					
		son's Disease, and				
	Hypertension.	•				

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	OF CORRECTION	, '		(x2) MULTIPLE CONSTRUCTION 00			SURVEY ETED
ANDILAN	OF CORRECTION	15G245	A. BUII	LDING		05/20	
		130243	B. WIN			03/20/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			DURTEENTH LN RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	The record revie Risk Plan for Cli The plan indicate for "having over sugar levels and come with poorly The plan indicate "staff will record Notify nurse of h reading <100>25 greater than 250 indicated the foll below 80 or abov Nurse immediate the reading to the follow the instru The Diabetic Pla included addition indicated day pro monitor any sign hyperglycemia a be posted at each indicated a nurse (Medication Adr month and the se review daily logs neglected to incl symptoms of hyp Diabetic Risk Pla specific paramete notification with	w indicated a Diabetic lent #1 dated 2/2013. ed Client #1 was at risk ly high or low blood the health concerns that y controlled Diabetes." ed the intervention of I his blood sugar daily. high or low glucose meter 50 [less than 100 or]." The plan also lowing: "If blood sugar is we 300, staff will call lely. The nurse will report the doctor or nurse and then ctions given to them." In for Client #1 also had instructions which the orgam staff would have of hypo or and indicated signs would be center. The plan the would review the MAR ministration Record) each ervice coordinator would so. The Diabetic Risk Plan		TAG	DEFICIENCY		DATE
	1						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G245	B. WIN			05/20/2013	
NAME OF P	PROVIDER OR SUPPLIER	\ {			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL IMPORTANT	IANIA INIC. THE			DURTEENTH LN		
	NORTHWEST INDI	·		HOBAR	T, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
		· · · · · · · · · · · · · · · · · · ·		0		Diff E	
	_	Diabetic Risk plan					
	~	staff what they were to					
		blood sugar was low					
		ent #1's Diabetic Risk					
		ted to indicate and/or					
		ent #1 was to have a					
	snack.						
	Client #1's 2/2013 to 5/2/2013 MARs indicated client #1's blood glucose levels						
	were monitored in the AM (morning),						
	Lunch, PM, Bedtime and as needed. The						
	·	Client #1 was prescribed					
		Flexpen to inject "15 units					
	_	neous injection] 2 times a					
		(Workshop Also).					
		od sugar) below 70 and					
	`	MAR indicated Client #1					
		order dated 9/14/10 for					
		alin at lunch time and					
	_	AR indicated the					
	following sliding	g scale was to be					
	administered:	-					
		log if blood sugar (b/s)					
	was between 100						
	-4 units of Novo	log if b/s was between					
	201-250						
	-6 units of Novo	log if b/s was between					
	251-300						
	-10 units of Nov	olog if b/s between					
	301-400						
	-12 units of Nov	olog if b/s was over 400.					
	The MARs also	indicated Client #1 had a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G245	B. WIN	IG		05/20/2013	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SUITELEN			4378 FC	DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		dated 9/16/10 for one can					
	of Glucerna (used to minimize blood						
	sugar spikes) giv	en three times daily.					
	Review of the M	IAR dated 4/01/13 to					
		MAR for 5/1/13 to 5/9/13					
		eglected to document the					
		f the sliding scale					
		ent #1 on the MAR as the					
		ARs were blank.					
	4/13 and 3/13 W	ARS WEIC DIAIR.					
	The documentati	ion for the administration					
		ding scale Novolog for					
		13 to 5/9/13 was located					
	<u> </u>	Subcutaneous Injection					
	form," not the M	· ·					
	lorin, not the m						
		ne Director of Health					
	Care (DHCS) on	5/9/13 at 2:23 PM					
	indicated she did	I not know where the					
	documentation f	or the sliding scale					
	Novolog was loc	cated, and staff should					
	have been docum	nenting administration of					
	the sliding scale	Novolog on the MAR					
	sheets for Client	#1.					
	Davious - £41 N	IADa for Client #1 from					
		ARs for Client #1 from					
		/2013 indicated the					
		d to document the units of					
		stered for the sliding					
		1's MAR. The MARS					
	indicated only st						
	administering the						
	documented "H"	for held. The number of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 05/20/2013			COMPLETED
		15G245	B. WIN			05/20/2013
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST IND	IANA INC, THE			DURTEENTH LN T, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		tts of the sliding scale	+	TAG	Dirichi.e.i,	DATE
		its of the sliding scale				
	Novolog was documented on the "Sites for Subcutaneous Injection," but the					
		d to document the amount				
		tered on 2/27/13, 3/1/13,				
	3/26/13, 3/31/13, 4/23/13, and 5/8/13 on any document. Client #1's blood sugar levels recorded on the 2/13 to 5/13 MARs indicated the facility staff administered the wrong					
	number of units of the Novolog sliding					
		eian orders, for Client #1				
	on the following					
		,				
	3/10/13 (lunch)	staff administered 6 units				
	instead of 4 unit	s for a b/s of 248				
	4/16/13 (bedtime	e) staff administered 4				
	units instead of	6 units for a b/s of 281				
	4/24/13 (bedtime	e) staff administered 6				
	units instead of	4 units for a b/s of 247				
	` ′	6 units were administered				
	instead of 10 for	a b/s of 303				
	` ′) staff administered 6				
	units instead of	4 units for a b/s of 243.				
	05/10/12 / 13	0.50 DM 1.31 1 C				
		2:58 PM, daily logs for				
		3/31/13 to 5/9/13 were				
		Client #1's Diabetic Risk				
	Plan, staff were	to call the nurse				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G245	A. BUI	LDING	00	COMPLI 05/20/2	
		130243	B. WIN			03/20/	2013
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE			T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY)		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENC!)	Į.	DATE
	immediately if Client #1 had a blood sugar (b/s) reading of either " <100>250"						
	_	greater than 250]" or ove 300." The daily log					
		the following blood					
		utside of the parameters					
	1 -	above 300" without					
		of nurse notification by					
	telephone:	Thurst nothiousion of					
	1						
	2/3/13 b/s 60 (lunch)						
	·						
	2/13/13 bedtime	(HS) 354					
	2/17/13 330 (lun	ch)					
	2/1/12 - 411. 1	1-206					
	3/1/13 at lunch b	0/S 306					
	3/18/13 b/s 309 ((HS)					
	3/20/13 b/s 322 ((lunch) and 327 (HS)					
	3/24/13 b/s 322 ((HS)					
	3/27/13 bedtime	(HS) b/s 305					
	3/29/13 at lunch	b/s of 202					
	JIZITIS at IUIICII	0/3 01 303					
	4/5/13 b/s 385 (I	HS)					
	., 5, 15 5, 5 5 5 5 (1	·-~)					
	4/7/13 b/s 305 (I	HS)					
		,					
	4/9/13 b/s 311 (1	unch) and 381 (HS)					
	Ì						
	I						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/20/2013		
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	4/21/13 b/s 80 (1	unch) and 50 (HS)					
	4/27/13 b/s 303 ((lunch)					
	4/29/13 b/s 360 ((HS).					
	Client #1's day s 2/1/13 to 5/10/13 #1's MARs indic lunch blood suga	00 PM, the MARs for ervice program from 3 were reviewed. Client cated the following before ar levels which were meter of less than 80 or					
	2/21/13 b/s 378						
	2/22/13 b/s 335						
	3/5/13 b/s 315						
	3/11/13 b/s 310						
	3/12/13 b/s 303						
	3/14/13 b/s 53						
	3/15/13 b/s 44						
	3/18/13 b/s 301						
	3/22/13 b/s 50						
	4/8/13 b/s 311						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G245		LDING	NSTRUCTION 00	COMP	ESURVEY LETED 0/2013	
	PROVIDER OR SUPPLIER		4378 FC	DDRESS, CITY, STATE, ZIP CODI DURTEENTH LN T, IN 46342	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	4/10/13 b/s 409					
	4/12/13 b/s 319					
	4/18/13 b/s 302					
	4/19/13 b/s 311					
	5/9/13 325					
	5/10/13 b/s 348.					
	5/9/13 indicated calls after hours blood sugar leve and 2/8/13. The of any calls from Client #1's blood Review of the M	ledication Change Form				
	his physician orc 2/13/13 upon dis from a "No Cond an "1800 ADA e Client #1's Annu dated 10/22/12 in consisted of no c the Glucerna sha Client #1's updat Assessment date	a indicated Client #1 had lered diet changed on scharge from the hospital centrated Sweets Diet" to easy to chew diet." hal Nutrition Assessment indicated Client #1's diet concentrated sweets with less three times daily. The ded Annual Nutritional ded 4/2013 indicated Client langed to a diabetic 1800				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		15G245	B. WIN			05/20/	2013
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		the Glucerna shakes					
	three times daily	•					
		s notes from $2/1/13$ to					
		ımulative Medical					
		nt #1 indicated the Nurse					
	•	notified on 2/9/13					
	regarding Client	#1's blood sugar level.					
	The Cumulative	Medical Record					
	indicated the fac	ility neglected to notify					
	the facility's nurs	se of any additional low					
	and/or high blood glucose readings as						
	specified by the	client's 2/13 risk plan.					
	Client #1's Cum	ılative Medical records					
	(nurses notes) in	dicated the facility's					
	,	neglected to monitor					
	_	blood sugar levels as there					
	_	tation in regard to the					
	client's blood sug	· ·					
		ord also indicated the					
	facility neglected	to contact the client's					
		to the client's low and/or					
		levels. Client #1's					
		lical Record indicated the					
		al refusals by Client #1:					
	i i i i i i i i i i i i i i i i i i i						
	On 5/4/12, the re	ecord indicated Client #1					
	•	complete a limited					
		after he had refused an					
	echocardiogram						
	Conocardiogram	Oπ ¬/ 1Δ/ 1Δ.					
	On 7/3/12 the o	umulative medical record					
		#1 would not allow any					
	part of his eye ex	•					
	part of fils eye ex	Main Other than					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G245	B. WIN	IG		05/20/2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	DURTEENTH LN	
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1 -	e record indicated Client				
		e sedated or have drops				
	1	3 minutes prior to exam.				
	_	indicated, "It is of dire				
	_	ive a dilated fundus exam				
	as it has NEVER					
	accomplished!!!	"				
	0 0/2/12 1	1 1. 1				
		umulative medical record				
	indicated Client #1 refused to have eye					
	drops administered into his eyes and the					
		re unable to complete his				
	-	The record indicated the				
	dilated eye exam	n occurred on 8/31/12.				
	On 1/16/2013, th	ne cumulative medical				
	record indicated	Client #1 "was				
	uncooperative" v	while getting lab work				
	_	an was unable to draw his				
	blood.					
	On 1/15/13, the	cumulative medical				
	record indicated	Client #1 "was				
	uncooperative" a	and was unable to				
	complete his poo	liatry appointment.				
	On 2/10/12 41.	overvlativa madical				
	l '	cumulative medical				
		Client #1 would not				
		cian to place electrodes or				
	do a scan for an	echocardiogram.				
	 On 3/19/13 Clie	ent #1 refused his blood				
	work.	in i rerused iils brood				
	WOIK.					
	I		- 1			[

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2013	
	PROVIDER OR SUPPLIEI NORTHWEST IND		4378 F	ADDRESS, CITY, STATE, ZIP CODE OURTEENTH LN RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	dated 2/28/13 in the client's interneglected to add for doctor appoin Client #1's Individual cumulative the facility and/o interdisciplinary after each hospir additional health. Review of training at 11:40 AM individual Supplement on (Individual Supplement of the train staff on hypo/hyperglyconinformation complan. An interview on Staff #6 indicate his lunch from hit.	r team neglected to meet tal visit to review in needs. Ing documents on 5/9/13 dicated residential staff Client #1's ISP port Plan) on 3/01/13 for the included Client #1's lan. The facility neglected signs and symptoms of the emia other than tained within the risk In 5/8/13 at 12:15 PM with the d Client #1 used to bring the mome but he wouldn't eat cated the day service staff			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G245	B. WIN	IG		05/20/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e group home. Staff #6					
indicated the Health and Safety							
		ked Client #1's blood					
		e lunch and then Client					
		he general menu lunch					
		f #6 indicated the day					
		not directly communicate					
	with group home	e staff regarding Client					
	#1's daily food in	ntake or concerns.					
	On 5/9/13 at 12:	33 PM, the Service					
	Coordinator (SC) and the Director of					
	Health Care Serv	vices (DHCS) were					
	interviewed. Th	e SC indicated it would					
	be the dietician's	responsibility to give the					
	facility guidance	on Client #1's 1800					
	calorie diabetic	diet. The SC indicated					
	she did not know	why there wasn't a					
		an for Client #1. The					
		the staff might have been					
	trained on how to	o "exchange" items on					
		sn't sure if training forms					
		An undated, non-client					
		ydrate Serving List" was					
		SC and the DHCS were					
		in what the list indicated					
	_	uld use this list to offer					
		iate meals. An "1800					
		Diabetic Association]					
	_	n was reviewed on 5/9/13					
		ich included a list of "No.					
		hanges." The SC and the					
		-					
		they had not seen that e DHCS indicated she					
	ionii before. Th	E DUCS illuicated sue					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 05/20/	ETED
	PROVIDER OR SUPPLIER		J. WINC	STREET A	DURTEENTH LN T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	in order to under indicated she did Client #1 a piece 5/8/13 prior to cl and before break there was no sch #1 as far as she was the SC indicated Client #1's annual Plan) which include specific and ADA calorie die snacks. On 5/9/13 at 4:5' LPN #1 indicated sugar was outsid Diabetic Risk Plarechecking the bindicated the problood sugar is not Client #1. LPN if for rechecking bit the risk plan for indicated there was range of acceptal Client #1 as his linstructed staff to blood sugar rang than 100 or great "below 80 or about the staff to blood sugar range there was not considered the not c	aining from the dietician stand the form. The SC not know why staff gave of bread at 6:30 AM on necking his blood sugar fast. The SC indicated edule of snacks for Client was aware. If she had trained staff on al ISP (Individual Service uded his diabetic plan on ted the training did not training on his 1800 t, menu substitutions, or PM, interview with diff Client #1's blood e the range given in the an, the staff should be lood sugar. LPN #1 tocol for rechecking the of in the risk plan for #1 indicated the protocol lood sugar should be in Client #1. LPN #1 was a discrepancy in the ble blood sugar levels for Diabetic Risk Plan or call the nurse for a se of "<100>250 [less ter than 250]' and/or ove 300." LPN #1 did not ange was correct for					

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	OF CORRECTION OF CORRECTION 15G245	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	4378 FC	ADDRESS, CITY, STATE, ZIP CODE DURTEENTH LN ET, IN 46342	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Client #1. LPN #1 indicated staff have been documenting blood sugar levels on the daily log and she receives those at least once weekly. LPN #1 didn't provide any further documentation staff called a nurse as Client #1's diabetic risk plan indicated. LPN #1 indicated she reviewed day service food intake, blood sugar levels, and MAR (medication administration record) on a monthly basis. LPN #1 indicated the staff at Client #1's group home had not been specifically trained on identifying signs and symptoms of high and low blood sugar. LPN #1 indicated she reviewed the client's MARs when she visited the group homes, or at the end of the month when they were faxed into the office. LPN #1 indicated she had started to track low blood sugars but did not track high blood sugar levels. LPN #1 indicated the staff received no client specific training for the signs and symptoms of high or low blood sugar. LPN #1 stated it was "inappropriate" for Client #1 to be offered three bowls of grits during breakfast on 5/8/13. LPN #1 indicated an adjustment was made for a diabetic diet on the April 2013 residential menu but no further menus had been developed. On 5/09/13 at 5:22 PM, the Behavioral Specialist indicated he wasn't sure if Client #1's IDT (interdisciplinary team) had met regarding the client's diabetes			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 05/20/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	4378 FC	DDRESS, CITY, STATE, ZIP CODE DURTEENTH LN T, IN 46342		
				<u> </u>	1, 111 40042		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	and hospitalizati						
	On 5/10/13 at 2: Staff #4 (Develor day services) start and Safety Technolic Client #1's blood noticed Client #1 hormal." HT #1 Client #1's blood Administrative Sto get Client #1 hadministrative Sto get Client #1 hadministrative Sto get Client #1 hadministrative Staff is blood sugar the soda. Administrative Staff is plans but we specific on an "The Administrative Staff is plans. A hindicated Client service program incident when Chospital with a bhadministrative Staff were symptoms of hypothesis but indicated his emergency protoclevel for Client #1. Administrative Staff were symptoms of hypothesis plans. A hindicated his emergency protoclevel for Client #1. Administrative Staff were symptoms of hypothesis had his emergency protoclevel for Client #1. Administrative Staff were symptoms of hypothesis had his emergency protoclevel for Client #1. Administrative Staff were symptoms of hypothesis had his emergency protoclevel for Client #1. Administrative Staff were symptoms of hypothesis had had his emergency protoclevel for Client #1. Administrative Staff were symptoms of hypothesis had	on PM, Administrative opmental Specialist for ted on 5/9/13, the Health nician (HT #1) took disugar level because staff a was "not acting a indicated she took disugar and it read 36. Staff #4 indicated staff ran a soda and called 911. Staff #4 indicated Client went up to about 54 after nistrative Staff #4 stated of were trained on the high ere not trained on 1800 calorie ADA diet." ive Staff #4 was not sure (American Diabetic t was specified in Client administrative Staff #4 #1 was also at the day during the 4/19/13 lient #1 went to the clood sugar of 30. Staff #4 indicated the day we trained on the signs and per and hypo-glycemia a staff were not trained on ocol and what blood sugar #1 would warrant a call to ative Staff #4 indicated etic Risk Plan does not					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G245	B. WIN			05/20/2013
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			4378 FC	OURTEENTH LN	
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	RT, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	indicate when to call 911.			TAG	DEFICIENCT)	DATE
	indicate when to	can 911.				
	On 5/10/12 at 2:	00 DM 11T #1 was				
	On 5/10/13 at 3:00 PM, HT #1 was interviewed and indicated Client #1 was					
	_	m on 5/9/13 when he				
	_	table. Staff called HT #1				
		#1's blood sugar. HT #1 "was combative" and she				
		taining his blood sugar				
	_	HT #1 indicated she tried				
		soda but he refused to				
	_	indicated Client #1 was				
		position and was				
	1 -	so they called 911. HT #1				
	1	s also present during the				
		. HT #1 indicated Client				
		oor in a fetal position 1911. HT #1 indicated				
	1	of the physician ordered				
		but indicated he does				
		nd only water with lunch.				
	_	staff were not trained on				
		when Client #1 refuses to				
		has been documenting				
		nd faxes it to the nurse				
		#1 indicated Client #1				
	1	nis lunch unless his blood				
	_	T #1 indicated Client #1				
		nis lunch later if his blood				
		T #1 indicated she would				
		when Client #1's blood				
	1	70 or over 200 by writing				
	_	iding scale form. HT #1				
		ew to call 911 when				
	mulcated SHC KII	CW to can 711 when				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G245		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 20/2013	
	PROVIDER OR SUPPLIEI		STREET A 4378 FC	ADDRESS, CITY, STATE, ZIP DURTEENTH LN RT, IN 46342	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	not know she m	d sugar was low but did ight need to call 911 if d sugar was too high.				
	Specialist indica discharged from on 5/9/13. No fi	1:11 AM, the Behavioral ted Client #1 had been his emergency room visit urther documentation or 5/9/13 incident were ew.				
	reviewed on 5/7 facility's 2/15/12 For Handling Ca Abuse indicated Indiana prohibit exploitation of of defined neglect and provide for client and anticiplacing of a clie a threat to his/he being" The p of neglect include to,depriving of	licy and procedures were /13 at 12:05 PM. The /2 policy entitled Policy ases Of Neglect And "1. The Arc Northwest s all abuse, neglect and our clients" The policy "as failure to consider the safety or care of the pate and remedy the int in a situation that poses or health and well olicy indicated examples ded, but were not limited dients of medical .not providing and mal care"				
	between 5:47 Al group home, clie in size. Client #	/8/13 observation period M and 8:00 AM, at the ent #2 was tall and small 2's shirt was big in size the client's body. Client				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	CON	TE SURVEY MPLETED	
		15G245	B. WING	1		20/2013
	PROVIDER OR SUPPLIER		4378 F	ADDRESS, CITY, STATE, ZIP (OURTEENTH LN RT, IN 46342	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	#2 ate one bowl wheat toast, app Staff #2 did not the client second Client #2's recor at 2:05 PM. Client	of grits, a slice of whole le juice and 1 cup of milk. encourage and/or offer ls of the breakfast meal. d was reviewed on 5/8/13 ent #2's 2012 and 2013 dicated the following (not 209 pounds 219 pounds 188 pounds 183 pounds 184 pounds 276 pounds 277 pounds 277 pounds 378 pounds 379 pounds		CROSS-REFERENCED TO THE		
	-February 2013 -March 2013 -April 2013 -April 2013 Client #2's Weig #2 was weighed were no addition Client #2's Cumindicated the fol -2/14/13 Client # The 2/14/13 con (behavior) medic #2's medication	167 pounds 178 pounds 176 pounds 159 pounds tht Chart indicated client once a month as there hal weights documented. Lulative Medical Record lowing (not all inclusive): Let 2 saw his psychiatrist. Les sult indicated Inderal cation was added to client regime as the client had creased aggression. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G245		(X2) MULTII A. BUILDIN		ISTRUCTION 00	CON	TE SURVEY MPLETED	
		15G245	B. WING			05/	20/2013
	PROVIDER OR SUPPLIER		43	78 FO	DDRESS, CITY, STATE, ZIP CO URTEENTH LN T, IN 46342	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
		ndicated the psychiatrist 2's Klonopin as there was higher dose."					
	continued treatm	\$2 saw his psychiatrist for tent. The consult sheet was mild improvement in vior.					
	doctor. The Cur "Wt (weight) I The 4/8/13 recor weight was 160 office. The reco doctor ordered la count), Chem, T Random Level, A	2 saw his primary care nulative Record indicated oss etiology unclear" It indicated client #1's pounds at the doctor's red indicated client #2's abs of "CBC (blood SH (thyroid test), ACTH (hormone test), nalysis) & (and) Ca-19-9 est)."					
	-4/17/13 "Abnor doctor]."	mal labs sent to [name of					
	indicated "Pt (pa chronic leukoper white blood cells (decreased numb blood) w/ (with) loss" The 4/2 client #2's labs fo The 4/25/13 note	ology/Oncology record tient) evaluated for mild nia (decreased number of s) & thrombocytopenia per of platelets in the progressive weight 5/13 record indicated or cancer were "normal." e indicated client #2 ands at the doctor's office.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G245	B. WIN	G		05/20/2013
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDER OR SUPPLIER			4378 FC	DURTEENTH LN	
	NORTHWEST IND	·			T, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ated "Plan- advise				
	* · · ·	edical doctor) to consider				
		(cat) scans if continued wt				
	loss w/o (withou	<i>'</i>				
	-Follow-up in 3	mo (months) to reassess.				
	-Possibly related	to his medications.				
	-0 (zero) sign of	malignancy."				
	Client #2's Cum	ulative Record indicated				
		doctor visits, the facility's				
		elected to document any				
		rd to the significant				
		veen the months of March				
	•					
		2013 and January 2013 to				
	February 2013.					
	Client #2's 2/1/1	3 physician's order				
	indicated client	#2's diet was changed to a				
	regular diet on 2	/1/13. Client #2's 5/13				
	physician's order	r indicated client #2 had				
	been on a "Portion	on Control" diet prior to				
	2/1/13 as the ord	ler for Portion Control				
	had "D/C" (disco	ontinue) written beside it.				
	`	physician's order did not				
	l '	en staff were to weigh				
	client #2.	on start were to weigh				
	Client #2's 10/22	2/12 Annual Nutritional				
	Assessment indi	cated client #2 weighed				
	176 pounds on 1	0/22/12. Client #2's ideal				
		s between 169 pounds and				
		e nutritional assessment				
	_	#2 received a Portion				
		e assessment indicated				
	Control diet. Th	e assessment maicated				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G245	B. WIN	IG		05/20/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			4378 FC	OURTEENTH LN	
	NORTHWEST IND	·		<u> </u>	T, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)	DATE
		continue a portion control				
		re to "Monitor Weight."				
		sessment did not indicate				
		were to weigh the client.				
	Client #2's 10/22	2/12 Nutritional				
	Assessment indi	cated the facility				
	neglected to info	orm the facility's dietician				
	of the client's sig	gnificant weight loss. The				
	assessment also	indicated the facility				
	failed to have the	e dietician re-assess client				
	#2 in regard to the	ne client's weight loss for				
	recommendations to assist the client from					
	further weight lo	oss.				
	 Client #2's 2/13/	13 Individual Support				
	Plan (ISP) indica	• •				
	` ′	team (IDT) neglected to				
		d/or address client #2's				
	· ·					
	_	ent #2's 2/13/13 ISP also				
		ility neglected to develop				
	a risk plan for cl	ient #2's weight loss.				
	Client #2's 2/13/	13 ISP and/or				
	Cumulative Med	lical Record indicated the				
	facility neglected	d to obtain clarification				
		ent #2 should be weighed				
		ient's weight loss.				
		<i>C</i>				
	Interview with s	taff #2 on 5/8/13 at 8:04				
	AM stated client	#2 was on a "Portion				
	Control diet." S	taff #2 indicated client #2				
	was not to have	seconds. Staff #2				
		#2 had been bigger in size				
	in the past but ha					

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMPL		
THAD TEAM	or condition	15G245		LDING		05/20/	
		100210	B. WIN		DDDEGG CITY CTATE ZID CODE	00/20/	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE DURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE			T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!		DATE
	I4	amina Canadinatan (SC)					
		ervice Coordinator (SC) 11:55 PM when asked if					
		ad met in regard to the					
		oss, SC #1 stated "Yes					
		dn't but the guardian,					
	-	SC#1) met by phone as					
		his losing weight." SC					
		nt #2's guardian was					
		the client losing weight.					
		client #2 was placed on a					
	•	13. SC #1 indicated she					
		t the meeting about client					
	ı	en asked if staff had been					
		to client #2's diet, SC #1					
		uld have been trained."					
		she was not sure if the					
	nurse had trained	1 staff.					
	Interview with th	ne Director of Health					
	Care Services (D	OHCS) on 5/10/13 at 1:40					
		ent #2 was going to the					
		e request of the client's					
		S stated client #2's					
	doctor indicated	the client's weight loss					
		hotropic medication."					
	Interview with a	dministrative staff #1 and					
	SC #1 on 5/10/13	3 at 1:45 PM indicated					
		at the group home in					
		#1 indicated she did not					
		cian had re-assessed the					
		lministrative staff #1					
	indicated client #						

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO.	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G245	B. WIN	_		05/20/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
4DC OF	NODTHWEST IND	ANA INC. THE			DURTEENTH LN		
	NORTHWEST INDI	ANA INC, THE		HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	monitored once	a montn.					
		777 114					
		PN #1 on 5/10/13 at 1:57					
		ent #2 had seen his					
		etor and oncologist for the					
	client's weight lo	ss. LPN #1 indicated					
		t weight in the past					
	month. LPN #1	indicated she had the					
	client weighed a	t the day program on their					
	scale. LPN #1 st	tated there had been a "20					
	pound weight di	fference." LPN #1					
	indicated she cal	led the client's oncologist					
	who told her to s	end the client to his					
	primary care doc	etor first. LPN #1					
		[‡] 2's doctor saw the client					
		to be done. LPN #1					
		me back on 4/8/13 and					
		rmal." LPN #1 indicated					
		s to the oncologist and					
	the primary care	· ·					
		cologist saw the client on					
		_					
		stated "He (doctor) feels					
		to medications." LPN #1					
		not know which					
		t #2's weight loss could					
		th. LPN #1 stated client					
		l once a month or					
		(LPN #1) request." LPN					
		e was no documented					
		e client's monthly					
	weights. LPN #1	indicated the facility's					
	dietician was not	due to be at client #2's					
	group home unti	1 5/20/13.					
				l			

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245		A. BUII	LDING	00	COMPL 05/20/	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OURTEENTH LN		
	NORTHWEST INDI				T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Έ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		icy and procedures were					
		13 at 12:05 PM. The					
	_	policy entitled Policy					
	For Handling Ca	ses Of Neglect And					
	Abuse indicated	"1. The Arc Northwest					
	Indiana prohibits	all abuse, neglect and					
	exploitation of or	ur clients" The policy					
	_	as failure to consider					
		he safety or care of the					
	*	pate and remedy the					
	_	nt in a situation that poses					
	a threat to his/her	_					
		plicy indicated examples					
	-	ed, but were not limited					
	to,depriving cl						
		not providing and					
	"adequate person	iai care"					
	0.0.0()						
	9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G245	B. WIN			05/20/	2013
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE			RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000154	483.420(d)(3)	-NIT OF OUTD					
		ENT OF CLIENTS					
	alleged violations	nave evidence that all					
	investigated.	are moreuginy					
	-	ew and record review for	W0	00154	Treatment of clients:		06/01/2013
	2 of 2 allegations	s of client to client abuse			Team meetings will be held to		
		cility failed to investigate			evaluate the effectiveness of Cl #2		
		f client to client abuse			behavior plan if necessary the plan		
		#2 at the facility's owned			will be revised. To ensure future		
	day program.	72 at the facility 5 owned			compliance, posters explaining clien	t	
	day program.				rights and reporting requirements		
	Findings include:				Including the need to report client		
					to client aggression, were distributed to all group homes and		
					the day program so that staff and		
		ortable incident reports,			clients become more aware of the		
		Accident Reports (I/A)			requirements on an ongoing basis.		
	and/or investigat	ions were reviewed on			Additionally all staff will be trained		
	5/7/13 at 11:53 A	AM. The facility's			on reporting and investigation		
	internal incident	reports indicated the			requirements for Abuse (including		
	following:				Client to client aggression), Neglect,		
					and Exploitation at least annually		
	-3/18/13 "[Client	t #2] slapped [day			unless changes occur or need		
	program client]	on part of face and neck."			requires this to be done more frequently.		
		indicated the day			To ensure that Service Coordinators		
	_	ad "redness to his neck."			are trained on reporting and		
	r-05-min on one in	- 2011200 00 1110 110011.			investigation requirements for		
	5/14/12 "[Client	t #2] threw an exercise			Abuse Neglect (including client to		
	-	ient's (female peer) head			client aggression), Exploitation and		
					injuries of unknown origin the		
		eason. The client was			Behavioral Health Director will		
	_	talking with staff. The			review their training records at least	t	
	_	at a table talking with			annually and document review of	,	
	_	reported to staff that			findings. Area Managers will review DSP training records to ensure they		
		(hearing voices) told			have been training at least annually		
	him that the clier	nt (female peer) was			and document review of findings.		
	talking about hin	n."			All new Service Coordinators and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPLE	ETED
		15G245	A. BUII			05/20/2	2013
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
450.05	NODEL WATER TAND				DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	' ⁻	DATE
					DSPs will be trained on reporting		
	The facility's ab	ava mantioned I/A reports			and investigation requirements for		
	_	ove mentioned I/A reports			Abuse Neglect (including the neglec	_t	
		ility did not conduct an			of medical care), Exploitation and		
	investigation in	regard to the client to			injuries of unknown origin prior to		
	client incidents	of aggression.			working a home or with a client. In		
					addition, the Service Coordinators		
	Interview with a	dministrative staff #1 on			will be present in their homes at		
					least two times per month to ensure	_	
		PM indicated the facility			protection of clients, address	-	
	_	te the 3/18/13 and/or			concerns, monitor activities, etc.		
	5/14/13 incident	s of client to client			Documentation of visits will be		
	aggression.				completed and will include specifics		
					to the client as well as the visit. The		
	9-3-2(a)				Behavioral Health Director will	,	
	9-3-2(a)				review progress notes regularly.		
					review progress notes regularly.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLI	ETED	
		15G245	B. WIN			05/20/	05/20/2013	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				OURTEENTH LN			
ARC OF	NORTHWEST INDI	ANA INC, THE			RT, IN 46342			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE	
W000210	483.440(c)(3) INDIVIDUAL PRO Within 30 days af interdisciplinary to assessments or re to supplement the conducted prior to Based on observe record review for (#2), the client's (IDT), failed to be re-assess a client weight loss. Findings include During the 5/8/11 between 5:47 AM group home, clie in size. Client #2 and hanging off #2 ate one bowl wheat toast, appl Staff #2 did not of the clients second Client #2's record at 2:05 PM. Client	DGRAM PLAN ter admission, the eam must perform accurate eassessments as needed e preliminary evaluation o admission. ation, interview and or 1 of 2 sampled clients interdisciplinary team have the dietician or in regard to the client's	W0	00210	Client #2 saw his hematologist 4/25/13 and will follow up on 7/25/13. He saw his primary physician on 4/8/13. He saw he psychiatrist and will follow up again on 6/5/13. All of these appointments involved an evaluation of his weight loss. dieitcian will evaluate CI #2 by 6/15/13. With input from these past appointments a risk plant client #2 was developed on 5/28/13 to include weekly weigh and guidelines for reporting changes. Following each appointment his risk plan will be evaluated and revised. All stawill be trained on this plan by 6/5/13. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessar skills. Additional training will be provided as the client's orders change and when new staff enthe house. To ensure his weight continues to be monitored clienting the saw in the house in the house of the monitored clienting the saw in the house. To ensure his weight of the monitored clienting the monitored clienting the differential training will be provided as the client's orders change and when new staff enthe house. To ensure his weight of the monitored clienting the monitored clien	The efor thts eff	06/01/2013	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DDIC	00	COMPLE	TED
		15G245	A. BUII B. WIN			05/20/2	2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	1			OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC. THE			RT, IN 46342		
			_				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		·		TAG	weight will be taken at the day	+	DATE
	-September 2012	•			program and sent to the nurse		
	-October 2012	176 pounds			a weekly basis, the Communit		
	-November 2012	*			Services Nurse will review the		
	-December 2012	169 pounds			weekly weights at least month	ly to	
	-January 2013	167 pounds			ensure they continue to be tak		
	-February 2013	178 pounds			Also, the spread sheet in whic		
	-March 2013	176 pounds			all client weights are charted he been modified to include auto	ias	
	-April 2013	159 pounds			formatting to identify individual	ls I	
	_	tht Chart indicated client			whom have had a greater than		
	_	once a month as there			10% weigh change over a thre		
		al weights documented.			month period. The community		
	were no addition	ar weights documented.			services clerk will distribute thi	S	
	Client #2's 2/1/1	3 physician's order			weight chart to all service coordinators and nursing staff		
					monthly so that any weight		
		#2's diet was changed to a			changes are addressed.		
	_	/1/13. Client #2's 5/13			_		
		r indicated client #2 had					
		on Control" diet prior to					
		er for Portion Control					
	had "D/C" (disco	ontinue) written beside it.					
		physician's order did not					
	indicate how ofto	en staff were to weigh					
	client #2.						
	Client #2's 10/22	2/12 Annual Nutritional					
	Assessment indi	cated client #2 weighed					
		0/22/12. Client #2's ideal					
	-	s between 169 pounds and					
	1 -	e nutritional assessment					
		#2 received a Portion					
		e assessment indicated					
		continue a portion control					
		re to "Monitor Weight."					
		sessment did not indicate					
	how often staff v	vere to weigh the client.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	\neg	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED	
		15G245	B. WIN			05/20/2013	
			P. (11)		ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF P	PROVIDER OR SUPPLIER	8			OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE			T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		N
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Client #2's 10/22						
		cated the facility failed to					
		ty's dietician of the					
	client's significat	nt weight loss. The					
	assessment also	indicated the facility					
	failed to have the	e dietician re-assess client					
	#2 in regard to the	ne client's weight loss for					
	recommendation	as to assist the client from					
	further weight lo	oss.					
	_						
	Interview with the	ne Director of Health					
	Care Services (E	OHCS) on 5/10/13 at 1:40					
		ent #2 was going to the					
		e request of the client's					
	_	CS stated client #2's					
		the client's weight loss					
		•					
	was "due to psyc	chotropic medication."					
	Interview with a	dministrative staff #1 and					
	SC #1 on 5/10/1	3 at 1:45 PM indicated					
	the dietician was	s at the group home in					
		#1 indicated she did not					
	_	cian had re-assessed the					
		lministrative staff #1					
	indicated client #						
	monitored once	•					
	monitored once	w 1110/11til.					
	Interview with L	PN #1 on 5/10/13 at 1:57					
	PM indicated cli	ent #2 had seen his					
		ctor and oncologist for the					
	1 *	oss. LPN #1 indicated					
	_	t weight in the past					
		indicated she had the					
	client weighed a	t the day program on their					

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Event ID: P3KB11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G245	B. WIN			05/20/	2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL IMPORTANT	IANA INO THE			DURTEENTH LN		
ARC OF	NORTHWEST IND	ANA INC, THE		HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		tated there had been a "20					
		fference." LPN #1					
		led the client's oncologist					
		end the client to his					
		etor first. LPN #1					
		[‡] 2's doctor saw the client					
		to be done. LPN #1					
	stated the labs ca	ame back on 4/8/13 and					
	they were "abnor	rmal." LPN #1 indicated					
	she faxed the lab	s to the oncologist and					
	the primary care	doctor. LPN #1					
	indicated the On	cologist saw the client on					
	4/25/13. LPN #	1 stated "He (doctor) feels					
	possibly related	to medications." LPN #1					
		l not know which					
	medication clien	t #2's weight loss could					
		th. LPN #1 stated client					
		l once a month or					
	•	(LPN #1) request." LPN					
		re was no documented					
		e client's monthly					
		indicated the facility's					
	_	t due to be at client #2's					
	group home unti						
	group nome und	1 3/40/13.					
	0.2.4(a)						
	9-3-4(a)						

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Event ID: P3KB11

Facility ID: 000768

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15G245	B. WIN			05/20/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE			RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000227	483.440(c)(4) INDIVIDUAL PRO The individual pro specific objectives client's needs, as comprehensive a paragraph (c)(3) of Based on record facility failed to objectives in the to address the cli appointments and recurrence of por hospitalizations/ with the client's of sampled clients (Findings include On 5/9/13 at 2:19 Client #1 indicate included, but we Diabetes Mellitu Anxiety, Parkins Hypertension. Review of nurses 5/9/13 in the "Cu Record" for Clie following medicate On 5/4/12, the re- was only able to	ogram plan states the sencessary to meet the identified by the sesessment required by of this section. review and interview, the include specific Individual Service Plan ident's refusals of medical delabs to prevent tential health risks associated diabetes for 1 of 3 (Client #1). PPM, a record review for red client #1's diagnoses re not limited to, so, Mental Retardation, con's Disease, and sentes from 2/1/13 to amulative Medical nt #1 indicated the all refusals by Client #1: record indicated Client #1 complete a limited after he had refused an	W0	00227	A BSP will be developed to address refusals of labs and medical assessments by 5/28/13. Each of the other consumer's plans will also be evaluated for the need for additional interventions. All of the consumers will have their behavior plan evaluated by the team at least annually and HRC two times per year. They will be updated as new behaviors become evident and as needed. Service coordinators will evaluate the need for modifications to the plan following all incident reports and during weekly observations.		06/01/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE S COMPLI	
		15G245	A. BUII B. WIN			05/20/	2013
	PROVIDER OR SUPPLIER			4378 FC	DURTEENTH LN		
	NORTHWEST INDI			HOBAR	T, IN 46342		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	indicated Client part of his eye experitionscopy. The #1 must either be installed on eyes. The optometrist importance to ha as it has NEVER accomplished!!!! On 8/3/12, the control indicated Client drops administer doctor's staff we eye assessment. In dilated eye example of the eye assessment. In the eye assessment in the eye assessment in the eye assessment. In the eye assessment in the eye assessment in the eye assessment in the eye assessment. In the eye assessment in the eye assessment in the eye assessment in the eye assessment. In the eye assessment in the eye assessment in the eye assessment in the eye assessment in the eye assessment. In the eye assessment in th	e record indicated Client e sedated or have drops 3 minutes prior to exam. indicated, "It is of dire eve a dilated fundus exam a [sic] been " " " " " " " " " " " " " " " " " "					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION II	DENTIFICATION NUMBER: 15G245	A. BUILDING B. WING	00 	COMPLETED 05/20/2013
	PROVIDER OR SUPPLIER	NA INC, THE	4378 F	ADDRESS, CITY, STATE, ZIP CODE OURTEENTH LN RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	On 3/19/13, Clien work. Client #1's Individed added 2/28/13 individed the client's interdiguated address the client's appointments, labs: On 5/09/13 at 5:22 Specialist indicated Client #1's IDT (in had met regarding)	t #1 refused his blood dual Support Plan (ISP) cated the facility and/or sciplinary team failed to s refusals for doctor s, and tests. 2 PM, the Behavioral d he wasn't sure if interdisciplinary team) the client's medical er documentation was			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (COMPLETED)					
		15G245	A. BUII B. WIN			05/20/	2013
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE			RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000318	care services req Based on observice record review, the Condition of Care Services for (#1 and #2). The Services failed to services met the clients it served. Care Services failed to services failed to services failed to and/or address a in regard to diable facility staff were diabetes and foll. The facility's He to ensure a client in regard to the colour blood sugar lever Care Services failed to ensure rediabetes were devel #2. The facility's failed to ensure rediabetes were addressed in the facility's failed to ensure rediabetes were addressed in the facility's failed to ensure respectifically addressed plan for client #1 Health Care Services Failed to ensure respectifically addressed plan for client #1 Health Care Services Failed to ensure respectifically addressed plan for client #1 Health Care Services Failed to ensure respectifically addressed plan for client #1 Health Care Services Failed to ensure respectifically addressed plan for client #1 Health Care Services Failed to ensure respectifically addressed plan for client #1 Health Care Services Failed to ensure respectifically addressed plan for client #1 Health Care Services Failed to ensure respectifically addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to ensure respectively addressed plan for client #1 Health Care Services Failed to en	ensure that specific health uirements are met. ation, interview and he facility failed to meet a Participation: Health ar 2 of 2 sampled clients he facility's Health Care health care needs of the are needs of the at the facility's Health health care needs health care services failed health Care Services failed health Care Services failed health care needed risk health care needed risk health care needed risk health care services he	W0	00318	The client was taken to the ER 5/9/13 and his blood sugar wa brought up to range then he w released. He was then taken the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was give on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to his reading, signs symptoms and response to low readings, notifying the community service nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/1 and began signing in at the hoon 5/20/13. Observations hav included meal time, medication administration, and documentation review of the MAR, blood sugar readings, at his journal. Nurses have begutaining staff on the Suppleme Lesson in Core A of Living in the Community, the revised risk ple (as noted above) reading blood sugars, administering insuling injections via flex pen, signs and symptoms of hyper and	s as	06/01/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245		A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURV COMPLETEI 05/20/201)	
		15G245	B. WIN			03/20/201	3
	ROVIDER OR SUPPLIER NORTHWEST INDI			4378 FC	ADDRESS, CITY, STATE, ZIP CODE DURTEENTH LN PT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE CO	(X5) MPLETION DATE
	for facility staff of failed to ensure facility's Health ensure the nursing client #1's diabet basis and notified indicated in the of The facility's He to ensure facility low and high bloomursing staff as of physician's order The facility's He to ensure nursing risk plan for client #1's diabeted in the consure nursing risk plan for client #1's Heach of the facility's He to ensure nursing risk plan for client #1's failed to ensure staff as and/or develop a weight loss. Please 2. The facility's failed to ensure staff as and/or develop and weight loss. Please 3. The facility's failed to ensure staff as and/or develop	to follow/implement, and facility staff were ed in regard to diabetes iabetic diet. The Care Services failed to a services monitored are on a more frequent deson a frequent deson a more frequent deson a more frequent deson and the Care Services failed a staff reported client #1's mod sugar readings to putlined by the client's and/or program plan. The alth Care Services failed a services developed a met #1's Urinary Tract and, failed to monitor misk plan for client #2's are see W331. Health Care Services failed in a sand diabetic menu the health needs of the see W342. Health Care Services medications were the physician's orders for			hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future training include modeling the appropria skills and return demonstration of the necessary skills. Additionally include training will be provided as the client's orders change and who new staff enter the house. In out to prevent reoccurrence all stawill be trained on the risk plant this training will include demonstration of reading blood sugars, administering insuling injections via flex pen and use the sliding scale (if applicable). The client high risk plan was modified on 5/9/13, and again 5/14/13, and again on 5/22/13. Additionally, a journal was developed on 5/9/13, staff wer trained on it 5/9/13 and it was implemented on 5/10/13 — whi includes blood sugar readings and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. A sea for glucometers that allow for uploading of reading will be investigated so readings can be reviewed in real time. In addit the use of electronic MARS will be investigated with upcoming new software. Until such time to	gs atte as sonal aren der aff d of . on . e ch	
	()						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2013			
	ROVIDER OR SUPPLIER NORTHWEST IND		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE			
				the staff have shown composing the skills, the nurse will continue to do observations home daily. Once competed has been demonstrated, the frequency of visits will decreated to every other day for two withen weekly for one month a monthly thereafter. Nursing trained staff on existing diated diets on 5/9/13 (these plans not at the home at the time survey). As orders have chand risk plans revised. Additatinings will be provided. The dietician to make a home viand develop sample 1800 of diabetic menus as guideline menu development by 5/22. The client's diabetic diet plate revised. In order to previse development by 5/22. The client's diabetic diet plate revised. In order to previse development by 5/22. The client's diabetic diet plate revised. In order to previse development by 5/22. The client's diabetic diet plate revised. In order to previse dietician via development by 5/22. The client's diabetic diet plate revised. In order to previse dietician via development dietician via demonstration on making exchanges and ider appropriate day time snacks. Following this training the dietician will visit the home of 2 weeks and will observe a and document her observat Nursing staff began visiting group home daily beginning 5/9/13 and began signing in home on 5/20/13. Observation have included meal time, medication administration, a documentation review of the MAR, blood sugar readings his journal. Nurses have be training staff on the Suppler Lesson in Core A of Living in the sugar readings his journal. Nurses have beta training staff on the Suppler Lesson in Core A of Living in the sugar readings his journal.	at the ncy exase reeks and staff petic swere of the anged litional The isit alorie es for 113. In will pent vill ogram g will htifying s. within meal ions. the g on g at the tions and example g, and egun mental			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2013
	ROVIDER OR SUPPLIER NORTHWEST IND		4378 F	ADDRESS, CITY, STATE, ZIP CODE OURTEENTH LN RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
				Community, the revised risk (as noted above) reading blo sugars, administering insulir injections via flex pen, signs symptoms of hyper and hypoglycemia and the use o glucerna specifically on 5/9/This training and future train include modeling the appropsion of the necessary skills. Add training will be provided as the client's orders change and we new staff enter the house. Additionally, a journal developed on 5/9/13, staff we trained on it 5/9/13 and it was implemented on 5/10/13 – we includes blood sugar reading and interventions, intake and applicable behavioral observations. The Commun Services Nurse will review the journal daily during their hone visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months at then monthly thereafter. Find Client #1 continues to see he doctor and specialist. His risplan will be modified following each visit as necessary and be distributed to the home a day program with additional training as needed. A risk place client #2 was developed on 5/28/13 to include weekly we and guidelines for reporting changes. All staff will be train this plan by 6/5/13. Client will be plan by 6/5/13. Client will be train this plan by 6/5/13. Client will be train this plan by 6/5/13.	and f f f f f f f f f f f f f f f f f f

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G245	A. BUILDING B. WING	00	COMPLETED 05/20/2013		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				be evaluated by his primary physician and dietician by 6/15/13. Any recommendation will be added to his risk plan. Nursing staff began visiting the group home daily beginning of 5/9/13 and began signing in at home on 5/20/13. Observation have included meal time, medication administration, and documentation review of the MAR. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessa skills. Additional training will be provided as the client's orders change and when new staff er the house. Daily visits will continue until staff have demonstrated competency and nurse monitoring will phase our according to competency demonstrated then monthly thereafter.	e n i the ns i the ns i d		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G245	B. WIN			05/20/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE			RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ГЕ	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000331	A83.460(c) NURSING SERV The facility must pervices in accord Based on observation interview for 2 of and #2), the facility nursing services in according to the facility nursing services facility nursing services facility nursing services facility nursing services facility states to follow/intensure facility states trained in regard client's diabetic deservices failed to diabetes on a monotify the physic client's program. Staff failed to enservices failed to enservices failed to enservices failed to enservices failed to enservices. The client's physic program plan. The failed to develop Urinary Tract Interview for 2 of and #2), the facility nursing services failed to enservices failed to enservices failed to enservices failed to enservices.	ICES provide clients with nursing dance with their needs. ation, record review, and f 2 sampled clients (#1 lity nursing services ally address/develop a nt #1's diabetes. The ervices failed to ensure a as developed for facility inplement, and failed to aff were adequately to diabetes and the diet. The facility nursing is monitor client #1's incertification frequent basis and ian as indicated in the The facility staff reported in high blood sugar ing staff as outlined by cian's order and/or the facility nursing staff a risk plan for client #1's fection (UTI) and, failed in develop a risk plan for	W0	TAG 00331	The client was taken to the ER 5/9/13 and his blood sugar was brought up to range then he was released. He was then taken to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was give on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to hig reading, signs symptoms and response to low readings, notifying the community service nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/1 and began signing in at the ho on 5/20/13. Observations havincluded meal time, medication administration, and documentation review of the MAR, blood sugar readings, at his journal. Nurses have begue	d en gh es d 3 me e e n end	06/01/2013
	Findings include				training staff on the Supplement Lesson in Core A of Living in the Community, the revised risk placed (as noted above) reading blood	ntal he ans	
	1. During the 5/8	8/13 observation period			sugars, administering insulin	u	
	_	M and 8:00 AM, at the			injections via flex pen, signs ar	nd	
		If #2 assisted client #1 to			symptoms of hyper and		
	group nome, star	1 #2 assisted chell #1 to			1 ' ''		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED
		15G245	B. WIN			05/20/2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	L			OURTEENTH LN	
ARC OF	NORTHWEST IND	IANA INC. THE			RT, IN 46342	
						T
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	` `	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETION DATE
TAG		<u> </u>		TAU	hypoglycemia and the use of	DATE
		r for the day at 6:05 AM.			glucerna specifically on 5/9/13	
	-	ff #2 went to the kitchen			This training and future training	
		lice of whole wheat bread			include modeling the appropria	
	and took the brea	ad to client #1 in his			skills and return demonstration	
	bedroom. At 6:5	52 AM, staff #3 prompted			of the necessary skills. Addition	
	client #1 to come	e and get his morning			training will be provided as the	
		ior to client #1 receiving			client's orders change and who	
		lications, staff #3 did a			new staff enter the house.In or to prevent reoccurrence all sta	
	_	which was 194 (test done			will be trained on the risk plan,	
	_	ceived the slice of bread).			this training will include	
		,			demonstration of reading bloo	d
		ed oral medications only			sugars, administering insulin	
		7:25 AM, staff #3			injections via flex pen and use	
		ed client #1 to leave the			the sliding scale (if applicable)	
	_	e to come back to the			The client high risk plan was modified on 5/9/13, and again	on
	medication room	n. Client #1 refused to			5/14/13, and again on 5/22/13	
	leave the dining	room table and was			Additionally, a journal was	
	attempting to ge	t food to eat. Staff #3			developed on 5/9/13, staff wer	e
		and the client's toast to			trained on it 5/9/13 and it was	
	_	#1 to follow her back to			implemented on 5/10/13 – whi	
		Client #1 left the dining			includes blood sugar readings and interventions, intake and	,
		followed staff #3 to the			applicable behavioral	
		7:43 AM, staff #3			observations. The Community	,
		*			Services Nurse will review this	
		volog 70/30 15 units of			journal daily during their home	
	,	s) via an insulin injection			visit. The Director of Health	
	*	Client #1 then returned			Services will monitor that the	
	_	m table to eat his			nursing staff is reviewing this information through weekly	
	breakfast. At 7:4	45 AM, client #1 was			meetings for three months and	<u>.</u>
	served one slice	of whole wheat toast, a			then monthly thereafter. A sea	
	bowl of grits, 1 s	small cup of apple juice, a			for glucometers that allow for	
	cup of milk and	a can of Glucerna (help			uploading of reading will be	
		sugar spikes) shake to			investigated so readings can b	
		client #1 ate the bowl of			reviewed in real time. In addit	
		ho was at the table			the use of electronic MARS wi be investigated with upcoming	
	_				new software.Until such time t	
	standing near cli	ent #1, asked client #1 if			1.5. Soltware. Onthi such time t	i i i i i i i i i i i i i i i i i i i

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Event ID: P3KB11

Facility ID: 000768

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED
		15G245	B. WIN			05/20/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L			OURTEENTH LN	
ARC OF	NORTHWEST IND	IANA INC, THE			T, IN 46342	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	he wanted more	grits. Staff #2 placed a			the staff have shown compete	ncy
	second serving of	of grits into client #1's			in the skills, the nurse will	the
	bowl. At 8:47 A	M, staff #2 asked client			continue to do observations at home daily. Once competence	
		more grits. Staff #2 then			has been demonstrated, the	'
		rving of grits into client			frequency of visits will decreas	e
	_	at #1 ate the bowl of grits			to every other day for two wee	ks
		is Glucerna shake. At			then weekly for one month and	
					monthly thereafter. Nursing sta	
	•	group home's kitchen, a			trained staff on existing diabet	
		a regular diet was posted			diets on 5/9/13 (these plans we not at the home at the time of	
	next to the refrigerator. The group home				survey). As orders have change	
	did not have an 1800 calorie diabetic diet				and risk plans revised. Addition	
	menu posted. The 5/8/13 menu indicated				trainings will be provided. The	:
	clients were to re	eceive apple juice, 1 bowl			dietician to make a home visit	
	of grits and a slice	ce of toast.			and develop sample 1800 cald	
					diabetic menus as guidelines f	
	Interview with s	taff #2 on 5/8/13 at 6:30			menu development by 5/22/13 The client's diabetic diet plan v	
		e was getting the slice of			be revised. In order to preven	
		#1. When asked why,			reoccurrence the dietician will	
		ne was getting the slice of			train both home and day progr	
					on the risk plan, this training w	ill
	_	t #1's] blood sugar will			include a demonstration on	·
		ff #2 indicated client #1's			making exchanges and identify appropriate day time snacks.	ying
	blood sugar wou	ld be high and then low.			Following this training the	
					dietician will visit the home with	hin
	Interview with s	taff #2 on 5/8/13 at 8:04			2 weeks and will observe a me	eal
	AM stated client	#1 was on a "diabetic			and document her observation	
	diet." When ask	ed where the diet was			Nursing staff began visiting the	
	posted, staff #2 of	could not locate the			group home daily beginning or	
	_	aff #2 then went to the			5/9/13 and began signing in at home on 5/20/13. Observation	
		stated client #1 was on			have included meal time,	.
		diabetic diet." Staff #2			medication administration, and	
		3 Menu which had an			documentation review of the	
	•	betic diet written in red			MAR, blood sugar readings, a	
					his journal. Nurses have begu	
	_	the menu. Staff #2			training staff on the Suppleme	
	indicated client #	#1 could have what was			Lesson in Core A of Living in t	IC

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	NINC	00	COMPL	ETED
		15G245	B. WING			05/20/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8			OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE			RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	Р	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	ì ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		gular menu unless		-	Community, the revised risk pl	lans	
		written in red by the menu			(as noted above) reading bloo		
		•			sugars, administering insulin		
		ty's posted May 2013			injections via a flex pen, signs		
	_	d not have any red			and symptoms of hyper and		
		5/13 menus for the			hypoglycemia and the use of glucerna specifically on 5/9/13	1	
		When asked what menu			This training and future training		
	staff #2 followed	d for client #1 at the			include modeling the appropria		
	breakfast meal, s	staff #2 indicated she			skills and return demonstration		
	followed the pos	sted menu in the kitchen.			of the necessary skills. Addition		
					training will be provided as the		
	Interview with s	taff #3 on 5/8/13 at 8:15			client's orders change and wh	en	
		ient #1 was diabetic and			new staff enter the house.Additionally, a journal w	100	
		calorie diabetic diet.			developed on 5/9/13, staff wer		
					trained on it 5/9/13 and it was	C	
		ed the posted menu in the			implemented on 5/10/13 – whi	ich	
		a regular diet. When			includes blood sugar readings		
		at #1 was to receive since			and interventions, intake and		
	he was on an 180	00 calorie diabetic diet,			applicable behavioral		
	staff #3 stated "V	We just know what he			observations. The Community		
	should have." S	taff #3 indicated staff did			Services Nurse will review this journal daily during their home		
	not assist client	#1 to measure his			visit. The Director of Health	•	
	food/servings. S	Staff #3 stated "He does			Services will monitor that the		
	_	sure it out. We do by			nursing staff is reviewing this		
		stated the group home			information through weekly		
	_	stated the group home schange." Staff #3 stated			meetings for three months and		
		•			then monthly thereafter. Finally	у,	
		ead equals 1 cup." Staff			Client #1 continues to see his doctor and specialist. His risk		
		ent #1 should not have			plan will be modified following		
		s of grits at the breakfast			each visit as necessary and w		
	meal. When ask	ted if staff #3 had been			be distributed to the home and		
	trained in regard	to signs and symptoms			day program with additional		
	of low and/or his	gh blood sugar, staff #3			training as needed.A risk plan	for	
	1	"some signs." Staff #3			client #2 was developed on	u la 4 a	
		#1 had not demonstrated			5/28/13 to include weekly weig	gnts	
		and/or high blood sugars			and guidelines for reporting changes. All staff will be trained	ed	
	• •				on this plan by 6/5/13. Client		
l	i when she worke	d. Staff #3 did not	1		and plan by 6/6/10. Official		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		15G245	B. WIN			05/20/2	2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L.		1	OURTEENTH LN		
ARC OF	NORTHWEST INDI	IANA INC, THE			RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	CORRECTION (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	specifically indic	cate she had been trained			be evaluated by his primary		
	and/or indicate when she was trained. During the 5/8/13 observation between				physician and dietician by		
					6/15/13. Any recommendation will be added to his risk plan.	is	
					Nursing staff began visiting the	_	
	_	2:28 PM at day service			group home daily beginning or		
		11 AM, Client #1 was			5/9/13 and began signing in at		
	1 .	at a table for lunch.			home on 5/20/13. Observation	ns	
	_				have included meal time,	,	
		usage pizza broken up			medication administration, and documentation review of the	1	
	_	d with Italian dressing and			MAR. This training and future		
		Staff #6 indicated Client			trainings include modeling the		
	#1 had already eaten his french fries				appropriate skills and return		
		M. Client #1 was			demonstrations of the necessa	-	
	observed to retur	rn to his day service			skills. Additional training will b		
	room. At 11:15	AM, Staff #7 was			provided as the client's orders change and when new staff er		
	observed to take	Client #1's lunch plate			the house. Daily visits will	ilei	
	from the microw	rave and offer it to him.			continue until staff have		
	Client #1 refused	d to eat anymore of his			demonstrated competency and nurse monitoring will phase out		
	lunch. Client #1	kept his cup of water					
	with him and cor	ntinued to drink the			according to competency demonstrated then monthly		
	water. At 11:22	AM, Client #1 was			thereafter.		
		l his glass of water at the					
		tly and then sit on the					
	_	AM, Client #1 was					
		nobs to straighten them					
		off carpet and eating it.					
	1 .	lient #1 was observed					
	· ·						
	_	uch holding his cup of					
		ng his water throughout					
		At 12:02 PM, the client's					
		bserved taped to a					
		t roster indicated Client					
ı		CS" (No Concentrated					
	Sweets) diet. At	12:24 PM, Client #1 was					
	offered another l	unch plate which he					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G245	B. WIN			05/20/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST INDI	ANA INC. THE			OURTEENTH LN RT, IN 46342		
					1, 111 40342	1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	refused to eat.	ESC IDENTIFY INC INFORMATION)		IAG			DATE
	Teruseu to eat.						
	On 5/7/12 at 11.	52 AM the Domest of					
	On 5/7/13 at 11:53 AM, the Bureau of Developmental Disabilities Services						
	•						
		and internal incident					
	_	iewed and indicated the					
	following:						
	4 DDDC	datad 2/12/12 indicated					
	•	dated 2/13/13 indicated eported Client #1's					
		1					
	disposition had changed and his blood sugar was checked. Staff reported Client						
	_	-					
		to eat and did not seem as					
		The report indicated					
		I sugar was above the					
		vel and the nurse					
		o take Client #1 to the					
	•	iately." The report					
		#1 was admitted to the					
		blood sugar and "a					
		n which may have caused					
	_	e." The report indicated					
		scharged from the					
	hospital on 2/13/	/13.					
		lent report dated 2/9/13					
		#1 had been reported sick					
		on $2/8/13$. The report					
	indicated Client						
	_	mal, he was not eating or					
	drinking." The r	report indicated Client #1					
		hospital. On 5/9/13 at					
		rse emergency call log					
	dated 2/9/13 indi	icated Client #1's blood					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	A. BUILI	DING	NSTRUCTION 00	(X3) DATE COMPL 05/20/	ETED
NAME OF F	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE	00/20/	2010
ARC OF	NORTHWEST INDI	ANA INC, THE			T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
		300's with irregular vitals mitted to the emergency					
	3/14/13 indicated milk when his be "unusual." The report of chair. On 5/9/13 and then the indicated Client paramedics to the waited for Client left. On 5/9/13 and urse emergency indicated Client before the parameter of the parameter	ort summary sheet dated de Client #1 was drinking ody motion became report indicated Client #1 and was about to fall out port indicated staff called nurse. The report #1 refused to go with the echospital and they at 2:39 PM, review of the reall log dated 3/14/13 #1's blood sugar was 52 redics had arrived. dated 4/19/13 indicated a sugar dropped to 30 at export indicated staff ec Client #1 soda but he curled up, and would not be report indicated Client #1 composite the composition of the nurse of indicated Client #1 from hospital after a lof 32 and a diagnosis of ection.					
	•	dated 4/25/13 indicated 0 PM, Client #1 was out					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	15G245		LDING	00	05/20/2013
		.002.0	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/20 10
NAME OF F	PROVIDER OR SUPPLIER	8			OURTEENTH LN	
	NORTHWEST IND	·			T, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
		y shopping when he				2332
		' and staff supported him				
		The report indicated an				
		driving by and was asked				
	to assist. The pa	ramedics checked Client				
	#1's blood sugar	which read 174. The				
		staff began to take Client				
		an when he began				
		port indicated the				
	. ^	e located and took Client				
	#1 to the hospital where he was checked					
	and released the	same day.				
	During interview	v on 5/9/13 at 5:35 PM,				
	the Behavioral S	pecialist indicated Client				
	#1 was in an am	bulance on his way to the				
	hospital due to lo	ow blood sugar levels.				
	On 5/9/13 at 2:1	9 PM, a record review for				
	Client #1 indicat	ted client #1's diagnoses				
	· ·	ere not limited to,				
		s, Mental Retardation,				
		son's Disease, and				
	Hypertension.					
		w indicated a Diabetic				
	Risk Plan for Cli	ient #1 dated 2/2013.				
	-	ed Client #1 was at risk				
		ly high or low blood				
	sugar levels and the health concerns that					
	come with poorly controlled Diabetes."					
		ed the intervention of				
		l his blood sugar daily.				
	Notity nurse of h	nigh or low glucose meter				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING		05/20/2013
	PROVIDER OR SUPPLIE		STREE* 4378	r address, city, state, zip code FOURTEENTH LN ART, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) 50 Floor than 100 or	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
IAG	reading <100>2 greater than 250 indicated the follow 80 or abo Nurse immediat the reading to the follow the instruction The Diabetic Plaincluded addition indicated day promonitor any sig hyperglycemia as be posted at eace indicated a nurs (Medication Admonth and the serview daily log to ensure Client included signs as hypo/hyperglycenursing services client's Diabetic specific parame notification with level due to con risk plan. Nursing ensure the Diabetic staff on what the #1's blood sugar Nursing service #1's Diabetic Ri	50 [less than 100 or of	IAG	DEFICIENCY)	DATE
	a snack.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G245		LDING		05/20/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	 Client #1's 2/201	3 to 5/2/2013 MARs					
		#1's blood glucose levels					
		in the AM (morning),					
		time and as needed. The					
		Client #1 was prescribed					
		Flexpen to inject "15 units					
	I -	neous injection] 2 times a					
	day (AM and PN	1) (Workshop Also).					
	Hold if B/S (block	od sugar) below 70 and					
	call nurse." The	MAR indicated Client #1					
	had a physician	order dated 9/14/10 for					
	sliding scale inst	alin at lunch time and					
	bedtime. The M	AR indicated the					
	following sliding	g scale was to be					
	administered:						
		log if blood sugar (b/s)					
	was between 100						
		log if b/s was between					
	201-250						
		log if b/s was between					
	251-300	1 (01/1)					
		olog if b/s between					
	301-400	-1: £1 -/					
		olog if b/s was over 400. indicated Client #1 had a					
	1 ^ -	dated 9/16/10 for one can d to minimize blood					
	`	ven three times daily.					
	sugai spikes) giv	on unce times daily.					
	Review of the M	IAR dated 4/01/13 to					
		MAR for 5/1/13 to 5/9/13					
		eglected to document the					
		f the sliding scale					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G245	B. WIN	G		05/20/2013	
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOIT EIEF				DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X:	5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DAT	E
		ent #1 on the MAR as the					
	4/13 and 5/13 M	ARs were blank.					
		ion for the administration					
		ding scale Novolog for					
	· ·	13 to 5/9/13 was located					
	on the "Sites for	Subcutaneous Injection					
	form," not the M	IAR.					
		27- 11					
		ne Director of Health					
	` ′	1 5/9/13 at 2:23 PM					
		l not know where the					
	documentation f	or the sliding scale					
	Novolog was loc	cated, and staff should					
	have been docur	nenting administration of					
	the sliding scale	Novolog on the MAR					
	sheets for Client	#1.					
	Review of the M	IARs for Client #1 from					
	2/1/2013 to 3/31	/2013 indicated the					
	facility neglected	d to document the units of					
	Novolog admini	stered for the sliding					
	scale on Client #	1's MAR. The MARS					
	indicated only st	aff initials for					
	administering th	e insulin and/or					
	documented "H"	for held. The number of					
	administered uni	its of the sliding scale					
		cumented on the "Sites					
	I -	s Injection," but the					
		d to document the amount					
		tered on 2/27/13, 3/1/13,					
		, 4/23/13, and 5/8/13 on					
	any document.	,					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	COM	TE SURVEY IPLETED
		15G245	B. WING			20/2013
	PROVIDER OR SUPPLIER NORTHWEST IND		4378 F	ADDRESS, CITY, STATE, ZIP FOURTEENTH LN RT, IN 46342	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the 2/13 to 5/13 facility staff adm number of units	I sugar levels recorded on MARs indicated the ninistered the wrong of the Novolog sliding ian orders, for Client #1 dates:				
	3/10/13 (lunch) sinstead of 4 units	staff administered 6 units s for a b/s of 248				
	`	e) staff administered 4 6 units for a b/s of 281				
	,	e) staff administered 6 4 units for a b/s of 247				
	4/27/13 (lunch) instead of 10 for	6 units were administered a b/s of 303				
	` '	staff administered 6 4 units for a b/s of 243.				
	Client #1 from 3 reviewed. Per C Plan, staff were immediately if C sugar (b/s) readi [less than 100 or "below 80 or about the content of the	2:58 PM, daily logs for /31/13 to 5/9/13 were lient #1's Diabetic Risk to call the nurse lient #1 had a blood ng of either " <100>250" greater than 250]" or ove 300." The daily log				
	sugar readings o of "below 80 or	utside of the parameters above 300" without of nurse notification by				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 20/2013
	PROVIDER OR SUPPLIEI		•	4378 FC	DDRESS, CITY, STATE, ZIP CO DURTEENTH LN T, IN 46342	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	telephone: 2/3/13 b/s 60 (lu	unch)					
	2/13/13 bedtime	e (HS) 354					
	2/17/13 330 (lur	nch)					
	3/1/13 at lunch l	o/s 306					
	3/18/13 b/s 309	(HS)					
	3/20/13 b/s 322	(lunch) and 327 (HS)					
	3/24/13 b/s 322	(HS)					
	3/27/13 bedtime	e (HS) b/s 305					
	3/29/13 at lunch	b/s of 303					
	4/5/13 b/s 385 (1	HS)					
	4/7/13 b/s 305 (1	HS)					
	4/9/13 b/s 311 (1	lunch) and 381 (HS)					
	4/21/13 b/s 80 (1	lunch) and 50 (HS)					
	4/27/13 b/s 303	(lunch)					
	4/29/13 b/s 360	(HS).					
		00 PM, the MARs for service program from					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COMPLETED 05/20/2013	
		15G245	B. WIN			05/20/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			DURTEENTH LN T, IN 46342		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	L	DATE
	2/1/13 to 5/10/13	were reviewed. Client					
	#1's MARs indic	ated the following before					
	lunch blood suga	ir levels which were					
	_	neter of less than 80 or					
	greater than 300:						
	2/8/13 b/s 388						
	_, _, _,						
	2/21/13 b/s 378						
	2/21/13 0/3 3/0						
	2/22/13 b/s 335						
	2/22/13 0/3 333						
	3/5/13 b/s 315						
	3/3/13 0/8 313						
	2/11/12 1-/- 210						
	3/11/13 b/s 310						
	2/12/12 1 / 202						
	3/12/13 b/s 303						
	3/14/13 b/s 53						
	3/15/13 b/s 44						
	3/18/13 b/s 301						
	3/22/13 b/s 50						
	4/8/13 b/s 311						
	4/10/13 b/s 409						
	4/12/13 b/s 319						
	4/18/13 b/s 302						
	4/19/13 b/s 311						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15G245	B. WIN			05/20/2	013
NAME OF F	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE		
ADC 0F	NODTHWEST IND	IANIA INC. THE			DURTEENTH LN .T, IN 46342		
	NORTHWEST IND	·			.1, IN 40342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE '	COMPLETION DATE
	REGOEMFORT OR			0			BIIIE
	5/9/13 325						
	3/ // 13 323						
	5/10/13 b/s 348.						
	3/10/13 0/3 3 10.						
	The nurse emerg	gency log from 2/1/13 to					
	1	the nurse had received					
		regarding Client #1's					
		ls on 3/14/13, 4/19/13,					
	and 2/8/13. There was no documentation						
	of any calls from day services regarding Client #1's blood sugar levels.						
	Review of the M	ledication Change Form					
	from 2/13 to 5/1	3 indicated Client #1 had					
	his physician ord	dered diet changed on					
	2/13/13 upon dis	scharge from the hospital					
	from a "No Cond	centrated Sweets Diet" to					
	an "1800 ADA e	easy to chew diet."					
	Client #1's Annu	al Nutrition Assessment					
	dated 10/22/12 is	ndicated Client #1's diet					
	consisted of no c	concentrated sweets with					
	the Glucerna sha	kes three times daily.					
	Client #1's updat	ted Annual Nutritional					
	Assessment date	d 4/2013 indicated Client					
		anged to a diabetic 1800					
	calorie diet with	the Glucerna shakes					
	three times daily						
		s notes from $2/1/13$ to					
	5/9/13 in the "Cumulative Medical						
		nt #1 indicated the Nurse					
	_	notified on 2/9/13					
	regarding Client	#1's blood sugar level.					

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		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL 05/20/	
		15G245	B. WIN			05/20/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ABC OF	NORTHWEST INC	NANA INC. THE			DURTEENTH LN RT, IN 46342		
					11, 111 40042		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG			DATE
1110		Medical Record	+	0			5.112
		cility staff failed to notify					
		rse of any additional low					
		od glucose readings as					
	_	client's 2/13 risk plan.					
		ulative Medical records					
		ndicated the facility's					
	` ′	failed to monitor client					
	_	sugar levels as there was					
	•	on in regard to the client's					
		els. The Cumulative					
	_	icated the facility nursing					
		o contact the client's					
	doctor in regard	to the client's low and/or					
	high blood suga						
	Review of train	ing documents on 5/9/13					
		dicated residential staff					
	were trained on	Client #1's ISP					
	(Individual Sup	port Plan) on 3/01/13 for					
	15 minutes which	ch included Client #1's					
	Diabetic Risk P	lan. The facility nursing					
	services failed to	o train staff on signs and					
	symptoms of hy	po/hyperglycemia other					
	than information	n contained within the risk					
	plan.						
	An interview on	1 5/8/13 at 12:15 PM with					
	Staff #6 indicate	ed Client #1 used to bring					
	his lunch from h	nome but he wouldn't eat					
	it. Staff #6 indi	cated the day service staff					
	tracked how mu	ch Client #1 ate					
	throughout the o	lay. Staff #6 indicated					
	Client #1 usuall	y ate his lunch unless his					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G245	B. WIN			05/20/	2013
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL IMPORTANT	IANIA INIC. THE			DURTEENTH LN		
	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		high during which case		TAG			DATE
		ent #1 his lunch later.					
	1 *	d Client #1 was also					
		snack at 2:30 PM and					
	_	te group home. Staff #6					
	indicated the He						
		ked Client #1's blood					
		re lunch and then Client					
		he general menu lunch					
		f #6 indicated the day					
		not directly communicate					
		e staff regarding Client					
	_ ^	ntake or concerns.					
		itake of concerns.					
	On 5/9/13 at 12:	33 PM, the Service					
) and the Director of					
	,	vices (DHCS) were					
		e SC indicated it would					
	be the dietician's	responsibility to give the					
		on Client #1's 1800					
		diet. The SC indicated					
	she did not know	why there wasn't a					
		an for Client #1. The					
		the staff might have been					
		o "exchange" items on					
		sn't sure if training forms					
		An undated, non-client					
	_	ydrate Serving List" was					
		SC and the DHCS were					
	not able to expla	in what the list indicated					
	_	uld use this list to offer					
	diabetic appropri	iate meals. An "1800					
		Diabetic Association]					
	_	m was reviewed on 5/9/13					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MULTIPLE A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 20/2013
	PROVIDER OR SUPPLIER		STREE 4378	T ADDRESS, CITY, STATE, ZIP FOURTEENTH LN ART, IN 46342	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
me	at 12:56 PM white [number] of excluder part of excluder p	ch included a list of "No. nanges." The SC and the they had not seen that e DHCS indicated she nining from the dietician stand the form. The SC not know why staff gave of bread at 6:30 AM on necking his blood sugar fast. The SC indicated edule of snacks for Client	THO I WAR TO SERVICE A SER			
	sugar was outsid Diabetic Risk Pl rechecking the b indicated the pro- blood sugar is no Client #1. LPN for rechecking b the risk plan for indicated there we range of accepta	e the range given in the an, the staff should be lood sugar. LPN #1 tocol for rechecking the ot in the risk plan for #1 indicated the protocol lood sugar should be in Client #1. LPN #1 vas a discrepancy in the ble blood sugar levels for Diabetic Risk Plan				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245		LDING	NSTRUCTION 00	(X3) DATE COMPI 05/20	ETED
	PROVIDER OR SUPPLIER		P . W.	STREET A	DURTEENTH LN T, IN 46342	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	blood sugar rangethan 100 or great "below 80 or about indicate which rate Client #1. LPN been documenting the daily log and least once weekled any further documents as Client #1 indicated. LPN day service food levels, and MAR administration results LPN #1 indicated group home had trained on identification sugar levels. LPN #1 indicated client's MARs whomes, or at the they were faxed indicated she had blood sugars but sugar levels. LP received no client signs and symptoms of great sugar. LPN #1 sugar.	d the staff at Client #1's not been specifically fying signs and h and low blood sugar. d she reviewed the hen she visited the group end of the month when into the office. LPN #1 d started to track low did not track high blood N #1 indicated the staff at specific training for the lows of high or low blood					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY LETED /2013
NAME OF	PROVIDER OR SUPPLIER	2			DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE			T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Staff #4 (Develor day services) start and Safety Tech Client #1's blood noticed Client # normal." HT # Client #1's blood Administrative Sto get Client #1 Administrative Staft is blood sugar the soda. Admin day services staft risk plans but we specifics on an "The Administrative Mether "ADA" Association) die #1's risk plan. A indicated Client service program incident when Chospital with a bear Administrative Staff were symptoms of hy but indicated his emergency protect level for Client # 911. Administrative Staff were symptoms of hy but indicated his emergency protect level for Client # 911. Administrative Staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms of hy but indicated his emergency protect in the staff were symptoms and staff were symptoms where the staff were symptoms were symptoms and staff were symptoms where symptoms were symptoms were symptoms where sympt	developed. 00 PM, Administrative opmental Specialist for sted on 5/9/13, the Health nician (HT #1) took disugar level because staff 1 was "not acting 1 indicated she took disugar and it read 36. Staff #4 indicated staff ran a soda and called 911. Staff #4 indicated Client went up to about 54 after nistrative Staff #4 stated if were trained on the high ere not trained on 1800 calorie ADA diet." ive Staff #4 was not sure (American Diabetic t was specified in Client administrative Staff #4 #1 was also at the day during the 4/19/13 lient #1 went to the blood sugar of 30. Staff #4 indicated the day the trained on the signs and per and hypo-glycemia a staff were not trained on bool and what blood sugar #1 would warrant a call to native Staff #4 indicated etic Risk Plan does not					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/20	ETED
	PROVIDER OR SUPPLIER			STREET A	DURTEENTH LN T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	Health and Safet was interviewed was in the day so 5/9/13 when he lead to staff called HT # blood sugar. HT combative" and obtaining his block HT #1 indicated #1 soda but he reindicated Client position and was called 911. HT # present during the #1 indicated Client a fetal position we #1 indicated she physician ordere indicated he doe water with lunch were not trained Client #1 refuses been documenting faxes it to the nuting indicated Client lunch unless his #1 indicated Client #1 indicated Client when Client #1's when Client #1's	call 911. 00 PM, the day services y Technician (HT #1) and indicated Client #1 ervices dining room on began to hit the table. #1 to check Client #1's #1 stated Client #1 "was she had difficulty od sugar which was 38. she tried to give Client efused to drink it. HT #1 #1 was getting into fetal "fighting them" so they e1 indicated she was also be 4/19/13 incident. HT ent #1 went to the floor in when they called 911. HT was unsure of the diet for Client #1 but is not get sweets and only it. HT #1 indicated staff on any protocol for when is to eat lunch but she has ing his food intake and irse bi-weekly. HT #1 #1 will usually eat his blood sugar is high. HT ent #1 will usually eat his blood sugar was under y writing it down on the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G245	B. WIN	G		05/20/2013
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			4378 FC	DURTEENTH LN	
	ARC OF NORTHWEST INDIANA INC, THE			HOBAR	T, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LISC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	_	m. HT #1 indicated she				
		when Client #1's blood				
	1 ~	ut did not know she might				
		if Client #1's blood sugar				
	was too high.					
		1:11 AM, the Behavioral				
	_	ted Client #1 had been				
	discharged from	his emergency room visit				
	on 5/9/13. No fi	urther documentation or				
	reports from the	5/9/13 incident were				
	available to revi	ew.				
	2. On 5/7/13 at	11:53 AM, the Bureau of				
	Developmental I	Disabilities Services				
	(BDDS) reports	and internal incident				
		iewed and indicated the				
	following:					
	-A BDDS report	t dated 4/19/13 indicated				
	_	d sugar dropped to 30 at				
		eport indicated staff				
		e Client #1 soda but he				
	1 .	curled up, and would not				
	1	e report indicated Client				
		ted to the hospital. On				
	_	M, review of the nurse				
		log indicated Client #1				
		from hospital after a				
	_	_				
	_	el of 32 and a diagnosis of				
	urinary tract infe	ection.				
	A DDDG	1-1-1 1/05/12 : 1: 1				
		t dated 4/25/13 indicated				
	i on 4/24/13 at /::	30 PM, Client #1 was out	ı			1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ì ') DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G245	A. BUILDING 00 COMPLETED 05/20/2013				
		130243	B. WIN		PRESIDENCE CONTROL CON	03/20/	2013
NAME OF F	PROVIDER OR SUPPLIER				DURTEENTH LN		
ARC OF	ARC OF NORTHWEST INDIANA INC, THE				T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		y shopping when he		TAG	,		DATE
		' and staff supported him					
		The report indicated an					
		driving by and was asked					
		ramedics checked Client					
	_	which read 174. The					
	_	staff began to take Client					
		an when he began					
		port indicated the					
	paramedics were	e located and took Client					
	#1 to the hospita	l where he was checked					
	and released the	same day.					
	On 5/9/13 at 2:1	9 PM, a record review for					
	Client #1 indicat	ed client #1's diagnoses					
	· ·	re not limited to,					
		s, Mental Retardation,					
	I	son's Disease, and					
	Hypertension.						
	Cliant #11a India	idual Support Plan (ISP)					
		dicated the facility's					
		failed to develop and add					
		lient #1's UTI diagnosis					
	on 4/19/13.	nent #1 5 O 11 diagnosis					
	OH 7/12/13.						
	On 5/9/13 at 12:	33 PM, the Service					
) was interviewed and					
	`	#1's fluids were increased					
	for 2 weeks as re	ecommended by the					
		physician after Client					
		pital visit due to a					
	diagnosis of Acu	ite Hematuria (blood					
	tinged urine). So	C indicated no risk plan					

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(X3) DATE SURVEY COMPLETED		
)/2013		
(X5) COMPLETION DATE		
DATE		

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[·			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00			COMPLETED	
		15G245	B. WING 05/20/2013				
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIER			4378 FC	DURTEENTH LN		
ARC OF NORTHWEST INDIANA INC, THE			HOBART, IN 46342				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGERGI	DATE	
	-November 2012	•					
	-December 2012	*					
	-January 2013	167 pounds					
	-February 2013	178 pounds					
	-March 2013	176 pounds					
	-April 2013	159 pounds					
	Client #2's Weig	ht Chart indicated client					
	#2 was weighed	once a month as there					
	were no addition	al weights documented.					
	Client #2's Cum	ulative Medical Record					
	indicated the foll	lowing (not all inclusive):					
		,					
	-2/14/13 Client #	‡2 saw his psychiatrist.					
		sult indicated Inderal					
		cation was added to client					
	` ′	regime as the client had					
		creased aggression. The					
		indicated the psychiatrist					
		2's Klonopin as there was					
		*					
	"no benefit from	nigher dose.					
	-3/19/13 Client #	\$2 saw his psychiatrist for					
		ent. The consult sheet					
		vas mild improvement in					
	the client's behav	-					
	-4/8/13 Client #2	2 saw his primary care					
		nulative Record indicated					
		oss etiology unclear"					
		rd indicated client #1's					
		pounds at the doctor's					
		rd indicated client #2's					
	uoctor ordered la	abs of "CBC (blood					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 20/2013
	PROVIDER OR SUPPLIER		STREE 4378	ET ADDRESS, CITY, STATE, ZIP FOURTEENTH LN ART, IN 46342	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	Random Level, A	SH (thyroid test), ACTH (hormone test), nalysis) & (and) Ca-19-9 est)."				
	-4/17/13 "Abnor doctor]."	mal labs sent to [name of				
	indicated "Pt (pa chronic leukoper white blood cells (decreased numb blood) w/ (with) loss" The 4/2 client #2's labs for The 4/25/13 note weighed 161 pout The record indic primary MD (me imaging w/ CT (loss w/o (without -Follow-up in 3 to	mo (months) to reassess. to his medications.				
	other than the 2 onursing staff fail concerns in regarmeight loss betw	alative Record indicated doctor visits, the facility's ed to document any rd to the significant reen the months of March 2013 and January 2013 to				

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i '			(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLETED 05/20/2013				
		15G245	B. WIN	IG		05/20/	2013	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE			
				4378 FOURTEENTH LN				
ARC OF NORTHWEST INDIANA INC, THE				HOBAR	T, IN 46342			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		3 physician's order						
		#2's diet was changed to a						
		/1/13. Client #2's 5/13						
		r indicated client #2 had						
		on Control" diet prior to						
		ler for Portion Control						
	,	ontinue) written beside it.						
		physician's order did not						
	indicate how ofto	en staff were to weigh						
	client #2.							
	Client #2's 10/22	2/12 Annual Nutritional						
	Assessment indi	cated client #2 weighed						
	176 pounds on 1	0/22/12. Client #2's ideal						
	body weight was	s between 169 pounds and						
	186 pounds. The	e nutritional assessment						
	indicated client #	#2 received a Portion						
	Control diet. Th	e assessment indicated						
	client #2 was to	continue a portion control						
	diet and staff we	ere to "Monitor Weight."						
	The 10/22/12 ass	sessment did not indicate						
	how often staff v	were to weigh the client.						
	Client #2's 10/22	•						
		cated the facility's						
		failed to inform the						
	facility's dieticia							
	<u>-</u>	ht loss to have the						
		ss client #2 in regard to						
	the client's weigh							
	and chieff worgh	1000.						
	 Client #2's 2/13/	13 Individual Support						
		ated the facility's nursing						
	` /	develop a risk plan for						
	client #2's weigh							
	Chent #28 weigh	it 1055.						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 05/20/2013				
		15G245	B. WIN			05/20/2013	
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF NORTHWEST INDIANA INC, THE					DURTEENTH LN et, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	DATE	
	Client #2's 2/13/	/13 ISP and/or					
		dical Record indicated the					
		services failed to obtain					
		how often client #2					
		ed to monitor the client's					
	weight loss.	ed to monitor the enem's					
	weight loss.						
	Interview with s	taff #2 on 5/8/13 at 8:04					
		t #2 was on a "Portion					
		taff #2 indicated client #2					
		seconds. Staff #2					
		#2 had been bigger in size					
	in the past but ha						
	in the past out ha	ad lost weight.					
	Interview with S	Service Coordinator (SC)					
		11:55 PM when asked if					
		nad met in regard to the					
		oss, SC #1 stated "Yes					
		idn't but the guardian,					
		(SC #1) met by phone as					
		this losing weight." SC					
		ent #2's guardian was					
		the client losing weight.					
		client #2 was placed on a					
		/13. SC #1 indicated she					
	_	nt the meeting about client					
		nen asked if staff had been					
	_	to client #2's diet, SC #1					
	_	ould have been trained."					
		she was not sure if the					
	nurse had trained						
	naise mad trainer	w swal.					
	Interview with the	he Director of Health					

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[·			(X2) M	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 05/20/2013				
		15G245	B. WIN			05/20/	2013
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
4 DO OF	NODEL IMPORTANT	IANIA INIC. THE	4378 FOURTEENTH LN				
ARC OF	ARC OF NORTHWEST INDIANA INC, THE			HOBAR	T, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		,		TAG	BEIGHACI		DATE
	` `	OHCS) on 5/10/13 at 1:40					
		ent #2 was going to the					
		e request of the client's S stated client #2's					
		the client's weight loss					
	was due to psyc	chotropic medication."					
	Intervious suits -	dministrative staff #1 and					
		3 at 1:45 PM indicated					
		at the group home in					
		#1 indicated she did not cian had re-assessed the					
		lministrative staff #1					
	indicated client #	•					
	monitored once	a month.					
	Interview with L	.PN #1 on 5/10/13 at 1:57					
	PM indicated cli	ent #2 had seen his					
	primary care doc	etor and oncologist for the					
	client's weight lo	oss. LPN #1 indicated					
	client #2 had los	t weight in the past					
	month. LPN #1	indicated she had the					
	client weighed a	t the day program on their					
	scale. LPN #1 st	tated there had been a "20					
	pound weight di	fference." LPN #1					
	indicated she cal	led the client's oncologist					
	who told her to s	send the client to his					
	primary care doc	etor first. LPN #1					
	indicated client #	#2's doctor saw the client					
	and ordered labs	to be done. LPN #1					
	stated the labs ca	nme back on 4/8/13 and					
	they were "abnor	rmal." LPN #1 indicated					
		s to the oncologist and					
	the primary care	_					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G245	A. BUILDING B. WING	00	COMPLETED 05/20/2013			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	indicated the Oncologist saw the client on 4/25/13. LPN #1 stated "He (doctor) feels possibly related to medications." LPN #1 indicated she did not know which medication client #2's weight loss could be associated with. LPN #1 stated client #2 was "weighed once a month or however often I (LPN #1) request." LPN #1 indicated there was no documented assessment of the client's monthly weights. LPN #1 indicated the facility's dietician was not due to be at client #2's group home until 5/20/13. 9-3-6(a)						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G245	B. WIN			05/20/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			OURTEENTH LN		
APC OF	NORTHWEST INDI	IANA INC. THE			RT, IN 46342		
				HODAI			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000342	483.460(c)(5)(iii)						
	NURSING SERV						
		must include implementing					
		ers of the interdisciplinary					
		e protective and preventive					
		that include, but are not direct care staff in					
		nd symptoms of illness or					
		aid for accidents or illness,					
		equired to meet the health					
	needs of the clien						
			W0	00342	The client was taken to the ER	R on	06/01/2013
	Based on observ	ation, interview and			5/9/13 and his blood sugar wa	S	
		ne facility's nursing			brought up to range then he w	as	
	· ·				released. He was then taken t	to	
		ensure staff were trained			the doctor on 5/14/13 by the		
	_	etes and diabetic menu			Service Coordinator and		
	required to meet	the health needs of 1 of 3			Community Services Nurse. A	4	
	sampled clients ((Client #1).			full medical assessment was	٨	
					completed. Labs were ordered and his sliding scale was	u	
	Findings include	•			discontinued. Advice was give	-n	
	1 111411185 11141444				on modifying his risk plan	21.1	
	Danis a 41 a 5/0/1	2 -1			including but not limited to		
	_	3 observation period			monitoring blood sugar, signs		
		M and 8:00 AM, at the			symptoms and response to hig	gh	
	group home, staf	ff #2 assisted client #1 to			reading, signs symptoms and		
	wake and showe	r for the day at 6:05 AM.			response to low readings,		
	At 6:30 AM, stat	ff #2 went to the kitchen			notifying the community service	es	
	· ·	lice of whole wheat bread			nurse, when to notifying the		
		ad to client #1 in his			physician, accurate use of a sliding scale (discontinued) an	Ч	
		52 AM, staff #3 prompted			the use of Glucerna. Nursing	u	
					staff began visiting the group		
		e and get his morning			home daily beginning on 5/9/1	3	
		ior to client #1 receiving			and began signing in at the ho		
	his morning med	lications, staff #3 did a			on 5/20/13. Observations hav		
	blood sugar test	which was 194 (test done			included meal time, medication	n	
	after client #1 re	ceived the slice of bread).			administration, and		
		ed oral medications only			documentation review of the		
		•			MAR, blood sugar readings, a		
	at tills time. At	7:25 AM, staff #3			his journal. Nurses have begu	ın	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		15G245	B. WIN			05/20/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	L			OURTEENTH LN	
ARC OF	NORTHWEST IND	IANA INC, THE			RT, IN 46342	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	verbally prompte	ed client #1 to leave the			training staff on the Suppleme	
	dining room tabl	e to come back to the			Lesson in Core A of Living in t	
	medication room. Client #1 refused to				Community, the revised risk pl	
		room table and was			(as noted above) reading bloo- sugars, administering insulin	a
	_	t food to eat. Staff #3			injections via flex pen, signs a	nd l
					symptoms of hyper and	
	_	and the client's toast to			hypoglycemia and the use of	
		#1 to follow her back to			glucerna specifically on 5/9/13	
		Client #1 left the dining			This training and future training	
		followed staff #3 to the			include modeling the appropriate skills and return demonstration	
	office area. At 7	7:43 AM, staff #3			of the necessary skills. Addition	
	administered No	volog 70/30 15 units of			training will be provided as the	
	insulin (Diabetes	s) via an insulin injection			client's orders change and who	
	pen to client #1.	Client #1 then returned			new staff enter the house.In or	
	_	m table to eat his			to prevent reoccurrence all sta	
		45 AM, client #1 was			will be trained on the risk plan,	
		of whole wheat toast, a			this training will include	
		small cup of apple juice, a			demonstration of reading blood sugars, administering insulin	,
					injections via flex pen and use	of
		a can of Glucerna (help			the sliding scale (if applicable)	
		sugar spikes) shake to			The client high risk plan was	
		client #1 ate the bowl of			modified on 5/9/13, and again	
	• •	ho was at the table			5/14/13, and again on 5/22/13	
	standing near cli	ent #1, asked client #1 if			Additionally, a journal was	
	he wanted more	grits. Staff #2 placed a			developed on 5/9/13, staff wer trained on it 5/9/13 and it was	
	second serving of	of grits into client #1's			implemented on 5/10/13 – whi	ch
	1	.M, staff #2 asked client			includes blood sugar readings	
		more grits. Staff #2 then			and interventions, intake and	
		rving of grits into client			applicable behavioral	
	_	at #1 ate the bowl of grits			observations. The community	
		is Glucerna shake. At			services nurse will review this	
					journal daily during their home visit. The Director of Health	
		group home's kitchen, a			Services will monitor that the	
	5/8/13 Menu for a regular diet was posted				nursing staff is reviewing this	
		erator. The group home			information through weekly	
	did not have an	1800 calorie diabetic diet			meetings for three months and	
	menu posted. Tl	he 5/8/13 menu indicated			then monthly thereafter. A sea	rch

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DINC	00	COMPLETED
		15G245	A. BUII B. WIN	LDING		05/20/2013
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF F	PROVIDER OR SUPPLIER	1		1	ADDRESS, CITY, STATE, ZIP CODE	
400.05	NODEL BAJECT IND	IANIA INIO TUE			OURTEENTH LN	
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	RT, IN 46342	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	clients were to re	eceive apple juice, 1 bowl			for glucometers that allow for	
	of grits and a slid	ce of toast			uploading of reading will be	
	01 81100 4114 4 511	01 10450			investigated so readings can b	
	Intomiore with a	taff #2 on 5/8/13 at 6:30			reviewed in real time. In addit	•
					the use of electronic MARS wi	
		e was getting the slice of			be investigated with upcoming new software.Until such time t	
	bread for client #	\$1. When asked why,			the staff have shown compete	
	staff #2 stated sh	ne was getting the slice of			in the skills, the nurse will	licy
	bread "So [client	t #1's] blood sugar will			continue to do observations at	the
	_	ff #2 indicated client #1's			home daily. Once competence	
		ld be high and then low.			has been demonstrated, the	, <u> </u>
	l blood sugai wou	nd be high and then low.			frequency of visits will decreas	e
		20.112			to every other day for two wee	
		taff #2 on 5/8/13 at 8:04			then weekly for one month and	
	AM stated client	#1 was on a "diabetic			monthly thereafter.Nursing sta	
	diet." When ask	ed where the diet was			trained staff on existing diabet	
	posted, staff #2 of	could not locate the			diets on 5/9/13 (these plans w	
		aff #2 then went to the			not at the home at the time of survey). As orders have chan	
		stated client #1 was on			and risk plans revised. Addition	-
					trainings will be provided. The	
		diabetic diet." Staff #2			dietician to make a home visit	
		3 Menu which had 1800			and develop sample 1800 cald	
	calorie Diabetic	diet written in red ink at			diabetic menus as guidelines f	or
	the top of the me	enu. Staff #2 indicated			menu development by 5/22/13	
	client #1 could h	ave what was written on			The client's diabetic diet plan v	
	the regular menu	unless something was			be revised. In order to preven	t
	_	the menu item. The			reoccurrence the dietician will	·om
		May 2013 regular menu			train both home and day progr on the risk plan, this training w	
					include a demonstration on	"
	1	red notations on the 5/13			making exchanges and identify	vina
		onth of May. When			appropriate day time snacks.	, 3
	asked what men	u staff #2 followed for			Following this training thedietic	cian
	client #1 at the b	reakfast meal, staff #2			will visit the home within 2 wee	
	indicated she fol	lowed the posted menu in			and will observe a meal and	
	the kitchen.				document her observations.	
	and mitorion.				Nursing staff began visiting the	
	T., 4 1	L-CC H2 5/9/12 9 15			group home daily beginning or	
		taff #3 on 5/8/13 at 8:15			5/9/13 and began signing in at home on 5/20/13. Observation	
	AM indicated cl	ient #1 was diabetic and			nome on bizoria. Observation	19

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		15G245	B. WIN			05/20/2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				OURTEENTH LN	
ARC OF	NORTHWEST IND	ANA INC. THE			T, IN 46342	
					11, 114 40042	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	` `	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		calorie diabetic diet.			have included meal time, medication administration, and	
	Staff #2 indicate	d the posted menu in the			documentation review of the	1
	kitchen was for a	a regular diet. When			MAR, blood sugar readings, a	nd
	asked what clien	t #1 was to receive since			his journal. Nurses have begu	
	he was on an 180	00 calorie diabetic diet,			training staff on the Suppleme	ntal
	staff #3 stated "V	We just know what he			Lesson in Core A of Living in t	
		taff #3 indicated staff did			Community, the revised risk pl	
		#1 to measure his			(as noted above) reading bloo sugars, administering insulin	a
		staff #3 stated "He does			injections via flex pen, signs a	nd
					symptoms of hyper and	ind .
		sure it out. We do by			hypoglycemia and the use of	
	1 -	stated the group home			glucerna specifically on 5/9/13	
	_	schange." Staff #3 stated			This training and future training	-
	"One slice of bre	ead equals 1 cup." Staff			include modeling the appropria	
	#3 indicated clie	nt #1 should not have			skills and return demonstration	
	received 3 bowls	s of grits at the breakfast			of the necessary skills. Addition training will be provided as the	
	meal. When ask	ed if staff #3 had been			client's orders change and who	
	trained in regard	to signs and symptoms			new staff enter the	
	_	gh blood sugar, staff #3			house.Additionally, a journal w	/as
	· ·	"some signs." Staff #3			developed on 5/9/13, staff wer	re
		‡1 had not demonstrated			trained on it 5/9/13 and it was	
					implemented on 5/10/13 – whi	I
	1	and/or high blood sugars			includes blood sugar readings and interventions, intake and	,
		d. Staff #3 did not			applicable behavioral	
	1 *	cate she had been trained			observations. The Community	,
	and/or indicate v	when she was trained.			Services Nurse will review this	
					journal daily during their home	
	During the 5/8/1	3 observation between			visit. The Director of Health	
	11:11 AM and 1	2:28 PM at day service			Services will monitor that the	
		11 AM, Client #1 was			nursing staff is reviewing this information through weekly	
		at a table for lunch.			meetings for three months and	1
		usage pizza broken up			then monthly thereafter. Finally	
		d with Italian dressing and			Client #1 continues to see his	
	•	•			doctor and specialist. His risk	
	_	Staff #6 indicated Client			plan will be modified following	
		aten his french fries			each visit as necessary and w	I
	around 11:00 AM	M. Client #1 was			be distributed to the home and	l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G245	B. WIN	IG		05/20/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		rn to his day service			day program with additional training as needed.A risk plan	for	
		AM, Staff #7 was			client #2 was developed on	101	
		Client #1's lunch plate			5/28/13 to include weekly weig	hts	
		rave and offer it to him.			and guidelines for reporting		
		d to eat anymore of his			changes. All staff will be trained		
	lunch. Client #1	kept his cup of water			on this plan by 6/5/13. Client was be evaluated by his primary	VIII	
	with him and con	ntinued to drink the			physician and dietician by		
	water. At 11:22	AM, Client #1 was			6/15/13. Any recommendation	ıs	
	observed to refil	l his glass of water at the			will be added to his risk plan.		
	sink independen	tly and then sit on the			Nursing staff began visiting the		
	couch. At 11:50	AM, Client #1 was			group home daily beginning or 5/9/13 and began signing in at		
	checking door ki	nobs to straighten them			home on 5/20/13. Observation		
	_	off carpet and eating it.			have included meal time,		
		lient #1 was observed			medication administration, and		
	· ·	uch holding his cup of		documentation review of the			
		ng his water throughout			MAR. This training and future trainings include modeling the		
		At 12:02 PM, the client's			appropriate skills and return		
		bserved taped to a			demonstrations of the necessar	ıry	
		t roster indicated Client			skills. Additional training will b	е	
		CS" (No Concentrated			provided as the client's orders	4	
		: 12:24 PM, Client #1 was			change and when new staff en the house. Daily visits will	ter	
	· · · · · · · · · · · · · · · · · · ·				continue until staff have		
		unch plate which he			demonstrated competency and	t	
	refused to eat.				nurse monitoring will phase ou	t	
	On 5/7/12 -4 11	52 AM 41 a Days C			according to competency		
		53 AM, the Bureau of			demonstrated then monthly thereafter.		
	_	Disabilities Services			moreulter.		
		and internal incident					
	_	iewed and indicated the					
	following:						
	A DDDC	1.4.10/10/10: 1: - 1					
		dated 2/13/13 indicated					
		eported Client #1's					
	_	changed and his blood					
	sugar was check	ed. Staff reported Client					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G245	B. WIN			05/20/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			OURTEENTH LN		
ARC OF	NORTHWEST IND				T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		to eat and did not seem as					
	active as usual.	The report indicated					
	Client #1's blood sugar was above the recommended level and the nurse						
	instructed staff t	o take Client #1 to the					
	hospital "immed	iately." The report					
	indicated Client	#1 was admitted to the					
	hospital for high	blood sugar and "a					
		on which may have caused					
		e." The report indicated					
	~	scharged from the					
	hospital on 2/13	•					
	nospital on 2/13/	13.					
	An internal incid	lent report dated 2/9/13					
		#1 had been reported sick					
		on 2/8/13. The report					
	1 1	#1's "vitals were					
		mal, he was not eating or					
	I -	report indicated Client #1					
	_	hospital. On 5/9/13 at					
		rse emergency call log					
		icated Client #1's blood					
	_	300's with irregular vitals					
	-	lmitted to the emergency					
	room.						
	-An incident ren	ort summary sheet dated					
	_	d Client #1 was drinking					
		ody motion became					
		report indicated Client #1					
		-					
		and was about to fall out					
		port indicated staff called					
		nurse. The report					
	indicated Client	#1 refused to go with the					

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Event ID: P3KB11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G245	B. WIN			05/20/	2013
NAME OF F	DROVIDED OD GLIDDLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF	C		4378 FC	OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG				TAG	DLI ICILIACI)		DATE
	-	e hospital and they					
		t #1 to eat before they					
		at 2:39 PM, review of the					
		y call log dated 3/14/13					
		#1's blood sugar was 52					
	before the param	nedics had arrived.					
	A DDDC man and	dated 1/10/12 indicated					
	_	dated 4/19/13 indicated					
		d sugar dropped to 30 at					
		eport indicated staff					
		e Client #1 soda but he					
	1	curled up, and would not					
		e report indicated Client					
	_	ted to the hospital. On					
		M, review of the nurse					
		og indicated Client #1					
	_	from hospital after a					
	_	el of 32 and a diagnosis of					
	urinary tract infe	ection.					
	-A BDDS report	dated 4/25/13 indicated					
	_	30 PM, Client #1 was out					
		y shopping when he					
		' and staff supported him					
		The report indicated an					
	_	driving by and was asked					
		aramedics checked Client					
	•	which read 174. The					
		staff began to take Client					
	-	van when he began					
		port indicated the					
		e located and took Client					
	-						
	-	l where he was checked					
	and released the	Same day.					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		15G245	B. WIN	G		05/20/201	13
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
4 DO OF	NODEL WATER IND	IANIA INIC. THE			DURTEENTH LN		
	NORTHWEST IND				T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	ì ·	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CC	OMPLETION DATE
1710	REGOLITORI OR	LEGO IDENTIFICATION ORGANIZATION		1110			DITTE
	During interview	v on 5/9/13 at 5:35 PM					
	During interview on 5/9/13 at 5:35 PM, the Behavioral Specialist indicated Client #1 was in an ambulance on his way to the hospital due to low blood sugar levels.						
	nospital aut to it	ov. 0100 u sugui 10 v 015.					
	On 5/9/13 at 2·1	9 PM, a record review for					
		ted client #1's diagnoses					
		ere not limited to,					
		is, Mental Retardation,					
		son's Disease, and					
	Hypertension.						
	The record revie	w indicated a Diabetic					
	Risk Plan for Cl	ient #1 dated 2/2013.					
	The plan indicat	ed Client #1 was at risk					
	for "having over	ly high or low blood					
	sugar levels and	the health concerns that					
	come with poorl	y controlled Diabetes."					
	The plan indicat	ed the intervention of					
	"staff will record	d his blood sugar daily.					
	Notify nurse of l	nigh or low glucose meter					
	reading <100>25	50 [less than 100 or					
]." The plan also					
		lowing: "If blood sugar is					
	below 80 or abo	ve 300, staff will call					
		ely. The nurse will report					
		e doctor or nurse and then					
		ctions given to them."					
		nn for Client #1 also					
		nal instructions which					
		ogram staff would					
	monitor any sigr						
	hyperglycemia a	and indicated signs would					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245		(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	COMP	E SURVEY LETED D/2013	
	PROVIDER OR SUPPLIER			STREET A 4378 FC	DDRESS, CITY, STATE, ZIP CODE DURTEENTH LN T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	indicated a nurse (Medication Adr month and the serview daily loggneglected to incl symptoms of hyp Diabetic Risk Plaspecific paramet notification with level due to confrisk plan. The Diabetic to instruct staff with Client #1's blood high. Client #1's blood high. Client #1's failed to indicate client #1 was to be Review of the Misphysician ord 2/13/13 upon disfrom a "No Condan "1800 ADA et al.	co/hyperglycemia. The an neglected to define a ser in regards to nurse. Client #1's blood sugar licting instruction on the riabetic Risk plan failed what they were to do if a sugar was low and/or and/or include when shave a snack. Tedication Change Form and indicated Client #1 had lered diet changed on charge from the hospital centrated Sweets Diet" to asy to chew diet." al Nutrition Assessment andicated Client #1's diet concentrated sweets with kes three times daily. Ted Annual Nutritional de 4/2013 indicated Client anged to a diabetic 1800 the Glucerna shakes					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) COMPLETED TO THE APPROPRIATE DATE A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342 (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE)	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE			15G245				05/20/	2013
ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 4378 FOURTEENTH LN HOBART, IN 46342 (X5) PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) ATACOMPLET TAG CMPLET TAG DEFICIENCY)	NAME OF DR	OVIDED OD SUDDI IED				ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE								
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY COMPLET DEFICIENCY DATE			<u> </u>		<u> </u>	11, IN 40342		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE						(EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
						CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
Review of training documents on 5/9/13 at 11:40 AM indicated residential staff were trained on Client #1's ISP (Individual Support Plan) on 3/01/13 for 15 minutes which included Client #1's ISP goals, behavior plan, medication, diet and dining needs, and high risk plans which included Client #1's Diabetic Risk Plan. The facility's nursing services failed to train staff on signs and symptoms of hypo/hyperglycemia other than information contained within the risk plan. On 5/9/13 at 12:33 PM, the Service Coordinator (SC) and the Director of Health Care Services (DHCS) were interviewed. The SC indicated it would be the dietician's responsibility to give the facility guidance on Client #1's 1800 calorie diabetic diet. The SC indicated she did not know why there wasn't a specific menu plan for Client #1. The DHCS indicated the staff might have been trained on how to "exchange" items on the menu but wasn't sure if training forms were completed. An undated, non-client specific "Carbohydrate Serving List" was reviewed but the SC and the DHCS were not able to explain what the list indicated or how staff should use this list to offer diabetic appropriate meals. An "1800 ADA [American Diabetic Association]		at 11:40 AM ind were trained on 0 (Individual Supp 15 minutes which ISP goals, behave and dining needs which included 0 Plan. The facility to train staff on shypo/hyperglyce information contents of the plan. On 5/9/13 at 12:20 Coordinator (SC Health Care Servinterviewed. The bethe dietician's facility guidance calorie diabetic of she did not know specific menu plan. DHCS indicated trained on how to the menu but was were completed. Specific "Carboh reviewed but the not able to explain or how staff should diabetic approprints."	icated residential staff Client #1's ISP Fort Plan) on 3/01/13 for the included Client #1's for plan, medication, diet as, and high risk plans Client #1's Diabetic Risk by's nursing services failed figns and symptoms of fimia other than fained within the risk 33 PM, the Service and the Director of frices (DHCS) were by SC indicated it would fresponsibility to give the fon Client #1's 1800 fliet. The SC indicated friend why there wasn't a for Client #1. The fine staff might have been for "exchange" items on for "exchange" items					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G245	B. WIN	G		05/20/2	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n was reviewed on 5/9/13					
		ch included a list of "No.					
		hanges." The SC and the					
		they had not seen that					
		e DHCS indicated she					
	would require tra	aining from the dietician					
	in order to under	stand the form. The SC					
	indicated she did	l not know why staff gave					
	Client #1 a piece	e of bread at 6:30 AM on					
	5/8/13 prior to c	hecking his blood sugar					
	and before break	fast. The SC indicated					
	there was no sch	edule of snacks for Client					
	#1 as far as she	was aware.					
	The SC indicated	d she had trained staff on					
	Client #1's annua	al ISP (Individual Service					
	Plan) which incl	uded his diabetic plan on					
	· · · · · · · · · · · · · · · · · · ·	ated the training did not					
		training on his 1800					
	_	t, menu substitutions, or					
	snacks.	,					
	On 5/9/13 at 4:5	7 PM, interview with					
		d the staff at Client #1's					
	group home had	not been specifically					
	trained on identi	2					
		sh and low blood sugar.					
		d the staff received no					
		aining for the signs and					
	_	th or low blood sugar.					
	1	was "inappropriate" for					
		ffered three bowls of					
		kfast on 5/8/13. LPN #1					
		ustment was made for a					
	muicaicu aii auji	isiment was made for a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G245	B. WIN			05/20/2	2013
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIC. THE			DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGHACT		DATE
		the April 2013 residential					
		ther menus had been					
	developed.						
	0: 5/10/12 -4 2::	OO DM Administration					
		00 PM, Administrative					
	`	pmental Specialist for					
	1 2	ted day services staff					
		the high risk plans but					
		on specifics on an "1800					
		t." The Administrative					
		sure whether "ADA"					
	`	etic Association) diet was					
	specified in Clie	•					
		Staff #4 indicated the day					
		e trained on the signs and					
		per and hypo-glycemia					
		staff were not trained on					
		ocol and what blood sugar					
		*1 would warrant a call to					
		ative Staff #4 indicated					
		etic Risk Plan does not					
	indicate when to	call 911.					
		00 PM, the day service					
		y Technician (HT #1)					
		and indicated she was					
		ysician ordered diet for					
		licated he does not get					
		water with lunch. HT #1					
		ogram staff were not					
		rotocol for when Client					
		lunch but she has been					
	_	food intake and faxes it					
	to the nurse bi-w	eekly. HT #1 indicated					

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
DIE		15G245		LDING		05/20/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	J
NAME OF P	ROVIDER OR SUPPLIER				OURTEENTH LN		
ARC OF	NORTHWEST INDI				T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		ually eat his lunch unless		TAG	,		DATE
		s high. HT #1 indicated					
	_	ually eat his lunch later if					
		s high. HT #1 indicated					
	_	the nurse when Client					
		was under 70 or over 200					
	_	vn on the sliding scale					
	-	licated she knew to call					
		#1's blood sugar was low					
	but did not know	she might need to call					
	911 if Client #1's	s blood sugar was too					
	high.						
	9-3-6(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G245	A. BUII B. WIN			05/20/	2013
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	OURTEENTH LN		
ARC OF	NORTHWEST INDI	ANA INC, THE			RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000368	483.460(k)(1) DRUG ADMINIST The system for dr assure that all drucompliance with the Based on record facility failed for (Client #1) to end administered per Findings include On 5/9/13 at 2:19 Client #1 indicate included, but we Diabetes Mellitut Anxiety, Parkinst Hypertension. Client #1's 2/201 were reviewed at blood glucose letthe AM (morning and as needed. The Client #1 was profile for the profile of the	TRATION rug administration must rugs are administered in he physician's orders. review and interview, the r 1 of 3 sampled clients sure medications were r the physician's orders. P PM, a record review for ed client #1's diagnoses re not limited to, s, Mental Retardation, on's Disease, and 3 to 5/2/2013 MARs and indicated client #1's vels were monitored in g), Lunch, PM, Bedtime The MARs indicated escribed Novolog 70-30 r"15 units Sub-Q jection] 2 times a day Vorkshop Also). Hold if r) below 70 and call R indicated Client #1 had r dated 9/14/10 for sliding runch time and bedtime.	W0	00368	The client was taken to the EI on 5/9/13 and his blood sugar was brought up to range then was released. He was then ta to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was give on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to hig reading, signs symptoms and response to low readings, notifying the Community Servit Nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/1 and began signing in at the hoon 5/20/13. Observations hav included meal time, medication administration, and documentation review of the MAR, blood sugar readings, at his journal. Nurses have begutraining staff on the Suppleme Lesson in Core A of Living in the Community, the revised risk pl	he ken e A d en gh ces d 3 me e n ntal he ans	06/01/2013
	nurse." The MA a physician order scale insulin at lu	R indicated Client #1 had r dated 9/14/10 for sliding unch time and bedtime.			his journal. Nurses have begutraining staff on the Suppleme Lesson in Core A of Living in t	in ntal he lans d	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		15G245		LDING		05/20/	2013
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NODTHWEST IND	IANIA INIC THE			OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	-2 units of Novo	log if blood sugar (b/s)			symptoms of hyper and		
	was between 10	0-200			hypoglycemia and the use of	,	
	-4 units of Novolog if b/s was between201-250-6 units of Novolog if b/s was between				glucerna specifically on 5/9/13 This training and future training		
					include modeling the appropri		
					skills and return demonstratio		
	251-300	log if o/s was between			of the necessary skills. Additi		
	-10 units of Novolog if b/s between				training will be provided as the		
		olog if b/s between			client's orders change and wh		
	301-400				new staff enter the house.In o		
		rolog if b/s was over 400.			to prevent reoccurrence all sta		
	The MARs also indicated Client #1 had a physician order dated 9/16/10 for one can				will be trained on the risk plan	,	
					this training will include demonstration of reading block	М	
	of Glucerna (use	ed to minimize blood			sugars, administering insulin	u	
	,	ven three times daily.			injections via flex pen and use	e of	
	1 2 1	IARs and "Site for			the sliding scale (if applicable		
		ejection Site" form for			The client high risk plan was		
		2/1/2013 to 5/18/2013			modified on 5/9/13, and again		
					5/14/13, and again on 5/22/13	.	
		eility documented			Additionally, a journal was developed on 5/9/13, staff we	ro.	
	_	e sliding scale Novolog			trained on it 5/9/13 and it was	E	
	but neglected to	document the number of			implemented on 5/10/13 – wh	ich	
	units administer	ed on the 2/27/13			includes blood sugar readings		
	(bedtime), 3/1/1	3 (bedtime), 3/26/13			and interventions, intake and		
		13 (bedtime), 4/23/13			applicable behavioral		
	(bedtime), and 5				observations. The Communit		
	//	d sugar levels recorded on			Services Nurse will review this		
		MARs indicated the			journal daily during their home visit. The Director of Health	9	
					Services will monitor that the		
	<u> </u>	ninistered the wrong			nursing staff is reviewing this		
		of the Novolog sliding			information through weekly		
	1	eian orders, for Client #1			meetings for three months and	d	
	on the following	dates:			then monthly thereafter. A sea	arch	
					for glucometers that allow for		
	3/10/13 (lunch)	staff administered 6 units			uploading of reading will be		
		s for a b/s of 248			investigated so readings can l		
		222 4 0/0 01 2 10			reviewed in real time. In addition the use of electronic MARS w		
	1/16/12 (1 14:	a) staff administance 1 4			be investigated with upcoming		
	4/10/13 (beatime	e) staff administered 4			I so invocagated with apooning	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		15G245				05/20/2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	1		1	ADDRESS, CITY, STATE, ZIP CODE		
450.05	NODEL NATE OF INDI				OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	units instead of 6	6 units for a b/s of 281			new software.Until such time t	hat	
					the staff have shown compete	ncy	
	1/21/13 (hadtime	e) staff administered 6			in the skills, the nurse will		
	`				continue to do observations at		
	units instead of 2	4 units for a b/s of 247			home daily. Once competency	y	
					has been demonstrated, the		
	4/27/13 (lunch)	6 units were administered			frequency of visits will decreas		
	instead of 10 for	a b/s of 303			to every other day for two wee then weekly for one month and		
					monthly thereafter. Nursing sta		
	5/6/13 (hedtime)	staff administered 6			trained staff on existing diabeti		
	` ′	units for a b/s of 243.			diets on 5/9/13 (these plans w		
	units instead of 2	t utilits for a b/s of 243.			not at the home at the time of		
					survey). As orders have chan	ged	
	The record revie	w indicated a Diabetic			and risk plans revised. Addition	onal	
	Risk Plan for Cli	ient #1 dated 2/2013.			trainings will be provided. The	;	
	The plan indicate	ed Client #1 was at risk			dietician to make a home visit		
		ly high or low blood			and develop sample 1800 calc		
		the health concerns that			diabetic menus as guidelines f		
	•				menu development by 5/22/13		
		y controlled Diabetes."			The client's diabetic diet plan v		
	The plan indicate	ed a nurse would review			be revised. In order to preven reoccurrence the dietician will		
	the MAR (Medic	cation Administration			train both home and day progr	am	
	Record) each mo	onth.			on the risk plan, this training w		
	ĺ				include a demonstration on		
	On 5/7/13 at 11:	53 AM, the Bureau of			making exchanges and identify	ying	
					appropriate day time snacks.		
	_	Disabilities Services			Following this training the		
		and internal incident			dietician will visit the home with		
	reports were rev	iewed and indicated no			2 weeks and will observe a me		
	reported medicat	tion errors from 2/1/13 to			and document her observation		
	5/8/13.				Nursing staff began visiting the		
					group home daily beginning or		
	On 5/9/13 at 4:57 PM, interview with LPN #1 indicated she reviewed the client's MARs when she visited the group				5/9/13 and began signing in at home on 5/20/13. Observation		
					have included meal time,	2	
					medication administration, and	<u>,</u>	
					documentation review of the		
	homes, or at the	end of the month when			MAR, blood sugar readings, a	nd	
	they were faxed	into the office. LPN #1			his journal. Nurses have begu		
	I	s not aware of any			training staff on the Suppleme		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	NOF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING B. WING		05/20/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES	4378 F	ADDRESS, CITY, STATE, ZIP CODE OURTEENTH LN RT, IN 46342	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112
	medication errors. No further documentation which indicated Client #1's residential MARs had been reviewed and/or monitored was available at the time. 9-3-6(a)		Lesson in Core A of Living in Community, the revised risk programs (as noted above) reading blow sugars, administering insuling injections via flex pen, signs a symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/1 This training and future training include modeling the appropriskills and return demonstration of the necessary skills. Addit training will be provided as the client's orders change and with new staff enter the house. Additionally, a journal developed on 5/9/13, staff we trained on it 5/9/13 and it was implemented on 5/10/13 – whincludes blood sugar reading and interventions, intake and applicable behavioral observations. The Community Services Nurse will review the journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months are then monthly thereafter. Finath Client #1 continues to see his doctor and specialist. His risinglan will be modified following each visit as necessary and we distributed to the home and day program with additional training as needed.	plans od and 3. ngs iate ons ional e nen was ere s nich s, ty is e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/20/2013		
	PROVIDER OR SUPPLIER		-	4378 F0	ADDRESS, CITY, STATE, ZIP CODE OURTEENTH LN RT, IN 46342	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
W000460	Each client must well-balanced die specially-prescribed specially-prescribed (#1), the facility prescribed 1800 Findings include During the 5/8/1 between 5:47 AM group home at 7: served one slice bowl of grits, 1 scup of milk and a minimize blood sconsume. Once grits, staff #2, who standing near clicked wanted more second serving or bowl. At 8:47 AM #1 if he wanted in placed a third serwing the wanted in placed at third serwing the wanted in the wanted in placed at third serwing the wanted in the wanted	ation, interview and r 1 of 2 sampled clients failed to follow a calorie diabetic diet.	W0	00460	As doctor's orders are revised dietician will adjust Cl#1 1800 calorie diabetic menus as guidelines for menu developm by 5/21/13. The client's diabed diet plan will be revised. In or to prevent reoccurrence the dietician will train both home aday program on the risk plan, training will include a demonstration on making exchanges and identifying appropriate day time snacks. Following this training the dietician will visit the home wit 2 weeks and will observe a mand document her observation in addition, the Service Coordinator, Nurse and Area Manager will visit the home at least weekly to observe a mean death of the coordinator of th	nent tic der and this	06/01/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G245	B. WIN			05/20/2	:013
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			DURTEENTH LN T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		eceive apple juice, 1 bowl					
	of grits and a sli	ce of toast.					
	D .: 11 . 5/0/1	2 -1					
	~	3 observation between					
	11:11 AM and 12:28 PM at day service program, At 11:11 AM, Client #1 was						
	1						
	_	at a table for lunch.					
		usage pizza broken up d with Italian dressing and					
	_	Staff #6 indicated Client					
		aten his french fries					
	1	M. Client #1 was					
		rn to his day service					
		AM, Staff #7 was					
		Client #1's lunch plate					
		vave and offer it to him.					
		d to eat anymore of his					
		kept his cup of water					
		ntinued to drink the					
		AM, Client #1 was					
		l his glass of water at the					
		tly and then sit on the					
	_	AM, Client #1 was					
		nobs to straighten them					
		off carpet and eating it.					
		lient #1 was observed					
	· · · · · · · · · · · · · · · · · · ·	uch holding his cup of					
	_	ng his water throughout					
		At 12:02 PM, the client's					
		bserved taped to a					
		et roster indicated Client					
		CS" (No Concentrated					
		t 12:24 PM, Client #1 was					
	· · · · · · · · · · · · · · · · · · ·	lunch plate which he					
		piaco milen ne					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G245	B. WIN	G		05/20/2013	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			4378 FC	DURTEENTH LN		
	NORTHWEST IND	·			T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LISC IDENTIFYING INFORMATION)		TAG	BEIGERGI	DATE	
	refused to eat.						
	0.5/5/40						
	On 5/7/13 at 11:53 AM, the Bureau of						
		Disabilities Services					
		and internal incident					
	reports were rev	iewed and indicated the					
	following:						
		dated 2/13/13 indicated					
	on 2/9/13 staff re	eported Client #1's					
	disposition had o	changed and his blood					
	sugar was check	ed. Staff reported Client					
	#1 did not want	eat and did not seem as					
	active as usual.	The report indicated					
		l sugar was above the					
		evel and the nurse					
		o take Client #1 to the					
		iately." The report					
	•	#1 was admitted to the					
		blood sugar and "a					
		n which may have caused					
	his sugar to raise	5.					
	An internal incid	lent report dated 2/9/13					
		#1 had been reported sick					
		on 2/8/13. The report					
	indicated Client	-					
		mal, he was not eating or					
	I -	report indicated Client #1					
		hospital. On 5/9/13 at					
		rse emergency call log					
		icated Client #1's blood					
	_	300's with irregular vitals					
	prior to being ad	mitted to the emergency					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G245	B. WIN	G		05/20/2013	
NAME OF F	PROVIDER OR SUPPLIEF		_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					OURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	room.						
	_	ort summary sheet dated					
	3/14/13 indicated Client #1 was drinking						
	milk when his be	ody motion became					
	"unusual." The	report indicated Client #1					
	began "twisting"	and was about to fall out					
	of chair. The rep	port indicated staff called					
	911 and then the	nurse. The report					
	indicated Client	#1 refused to go with the					
	paramedics to th	e hospital and they					
	waited for Clien	t #1 to eat before they					
		at 2:39 PM, review of the					
		call log dated 3/14/13					
		#1's blood sugar was 52					
		nedics had arrived.					
	before the param	icares maa arrivoa.					
	-A BDDS report	dated 4/19/13 indicated					
		l sugar dropped to 30 at					
		eport indicated staff					
		e Client #1 soda but he					
		curled up, and would not					
	_	e report indicated Client					
		ed to the hospital. On					
	_	M, review of the nurse					
		og indicated Client #1					
		from hospital after a					
	_	of 32 and a diagnosis of					
	urinary tract infe	CHOII.					
	-A RDDS report	dated 4/25/13 indicated					
	_	30 PM, Client #1 was out					
		y shopping when he					
	appeared weak'	' and staff supported him					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SI	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G245	B. WIN	G		05/20/2	013
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					DURTEENTH LN		
ARC OF	NORTHWEST IND	IANA INC, THE		HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	The report indicated an					
		driving by and was asked					
	_	nramedics checked Client					
	#1's blood sugar which read 174. The						
	_	report indicated staff began to take Client					
		van when he began					
		port indicated the					
	_	e located and took Client					
		l where he was checked					
	and released the	same day.					
	-	v on 5/9/13 at 5:35 PM,					
		Specialist indicated Client					
		bulance on his way to the					
	hospital due to le	ow blood sugar levels.					
	On 5/9/13 at 2:1	9 PM, a record review for					
		ted client #1's diagnoses					
		as not limited to, Diabetes					
	Mellitus.	is not initied to, Didoctes					
	Wichitus.						
	The record revie	ew indicated a Diabetic					
		ient #1 dated 2/2013.					
		ed Client #1 was at risk					
	_	'ly high or low blood					
		the health concerns that					
	_	y controlled Diabetes."					
	come with poort	y controlled Diauctes.					
	Client #1's 2/2013 to 5/2/2013 MARs indicated client #1's blood glucose levels						
		in the AM (morning),					
		•					
	MARs indicated	Itime and as needed. The Client #1 was prescribed Flexpen to inject "15 units					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G245	B. WIN	G		05/20/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					OURTEENTH LN	
ARC OF	NORTHWEST INDI	IANA INC, THE		HOBAR	T, IN 46342	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
IAG		LSC IDENTIFYING INFORMATION)		TAG	BEI ICIENCI)	DATE
		neous injection] 2 times a				
	, ,	M) (Workshop Also).				
	,	od sugar) below 70 and				
		MAR indicated Client #1				
		order dated 9/14/10 for				
	_	alin at lunch time and				
	bedtime.					
	Client #1's under	ted Annual Nutritional				
	_	d 4/2013 indicated Client				
		anged to a diabetic 1800				
		the Glucerna shakes				
	three times daily					
	Interview with st	taff #2 on 5/8/13 at 8:04				
	AM stated client	#1 was on a "diabetic				
	diet." When ask	ed where the diet was				
	posted, staff #2 o	could not locate the				
	diabetic diet. Sta	aff #2 then went to the				
	staff's office and	stated client #1 was on				
	an "1800 calorie	diabetic diet." Staff #2				
	had an April 201	3 Menu which had 1800				
		diet written in red ink at				
	the top of the me	enu. Staff #2 indicated				
	client #1 could h	ave what was written on				
	the regular menu	unless something was				
	written in red by	the menu item. The				
	facility's posted	May 2013 regular menu				
	did not have any	red notations on the 5/13				
	menus for the me	onth of May. When				
		u staff #2 followed for				
	client #1 at the b	reakfast meal, staff #2				
		lowed the posted menu in				
	the kitchen.	•				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE COMPI 05/20		
	PROVIDER OR SUPPLIER			4378 FC	DDRESS, CITY, STATE, ZIP COD DURTEENTH LN T, IN 46342	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	AM indicated cliwas on an 1800 of Staff #2 indicate kitchen was for a asked what clien he was on an 180 staff #3 stated "V should have." So not assist client # food/servings. So not have to meassight." Staff #3 was using "an ex "One slice of bre #3 indicated clie received 3 bowls meal. An interview on Staff #6 indicate his lunch from hit.	taff #3 on 5/8/13 at 8:15 tent #1 was diabetic and calorie diabetic diet. If the posted menu in the a regular diet. When the #1 was to receive since to calorie diabetic diet, we just know what he taff #3 indicated staff did #1 to measure his taff #3 stated "He does the fact the group home thange." Staff #3 stated and equals 1 cup." Staff the hould not have to fight at 1 should not have to fight at 1 should not have to fight at 1 used to bring the component of the calories at 1 at 2:15 PM with the diabet at 2 at 4 at 4 at 4 at 4 at 4 at 4 at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: P3KB11

Facility ID: 000768

If continuation sheet

Page 120 of 122

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION 15G245		OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	UMBER: A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342 CIENCIES ID PROVIDER'S PLAN OF CORRECTION COMPLETED 05/20/2013 COMPLETED 05/20/2013 (X5)				
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5/8/13. LPN #1 indicated an adjustment was made for a diabetic diet on the April 2013 residential menu but no further								
was made for a diabetic diet on the April 2013 residential menu but no further		_	-					
2013 residential menu but no further								
			_					
menus had been developed.								
		menus had been	developed.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: P3KB11

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G245		(X2) MULTIPLE CO A. BUILDING B. WING	00	CO	COMPLETED 05/20/2013	
	PROVIDER OR SUPPLIE		STREET A 4378 FC	ADDRESS, CITY, STATE, ZIP C DURTEENTH LN ST, IN 46342	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	9-3-8(a)					

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Event ID: P3KB11

Facility ID: 000768

If continuation sheet

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